



JUN-15-2009 16:19

UMC DIGESTIVE DISORDERS - GASTRO

6019844648 P.045

Page 2 of 2

PROXIMAL ALONG THE GREATER CURVATURE. A MARK WAS THEN MADE AT THIS POINT ALONG THE GREATER CURVATURE. A SUBCUTANEOUS POCKET FOR THE NEUROSTIMULATOR WAS CREATED IN THE RIGHT UPPER QUADRANT JUST BELOW THE COSTAL MARGIN.

DR. ABELL PERFORMED ESOPHAGOGASTROSCOPY, INTUBATING THE STOMACH WITH GASTROSCOPE. A POINT ON THE GREATER CURVATURE WAS PICKED FOR LEAD PLACEMENT. THESE LEADS WERE PLACED IN THE GASTRIC WALL NEAR THE GREATER CURVATURE NEAR PREVIOUS MARKING. TWO LEADS WERE PLACED UNDER DIRECT VISUALIZATION BY EGD. THE LEADS WERE THEN SECURED TO THE PLASTIC DISC USING STAPLER AND SUTURING DISC TO THE GASTRIC WALL INTO 2 POINTS. THE HUB OF THESE LEADS WAS SUTURED TO THE GASTRIC STOMACH USING SILK. IMPEDENCE WAS VERIFIED THROUGH THESE LEADS, WHICH WAS ELEVATED DESPITE MANIPULATION OF THE LEADS. A THIRD LEAD WAS THEN PLACED JUST PROXIMAL TO THE PREVIOUS LEADS, AND THIS WAS SECURED IN THE SAME FASHION. THIS NEW LEAD WAS USED ALONG WITH THE MOST DISTAL LEAD. IMPEDENCE WAS VERIFIED AT APPROXIMATELY 840. THE LEADS WERE THEN BROUGHT THROUGH THE FASCIA TOWARD THE SUBCUTANEOUS POCKET AND RECONNECTED TO THE NEUROSTIMULATOR. THE POCKET WAS IRRIGATED AND CLOSED USING A SERIES OF 2-0 VICRYL SUTURES. THE FASCIA WAS THEN CLOSED WITH #1 LOOP PDS, AFTER THE STOMACH AND WIRES WERE REDUCED INTO THE PERITONEAL CAVITY. THE WOUND WAS IRRIGATED AND THE SKIN WAS CLOSED USING 4-0 MONOCRYL IN RUNNING SUBCUTICULAR STITCH.

THE PATIENT TOLERATED THE PROCEDURE WELL. SHE WAS EXTUBATED IN THE OPERATING ROOM AND TRANSPORTED TO THE RECOVERY ROOM IN STABLE CONDITION. FINAL INDEPENDENCE MEASURED JUST ABOVE 800.

ELECTRONICALLY AUTHENTICATED BY  
JIHAD RIAD SALAMEH, M.D. 08/22/2005 09:57

Dictated by: LADAWN TALBOTT, M.D.  
D: 08/15/2005  
T: 08/15/2005 2:27 P  
1413806/000856265

CC: JIHAD RIAD SALAMEH, M.D.

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<http://oasgold.umc.edu/a0a6-ntap-bin/webcfch.exe/PRD/27KEY=PT0002INVSIONPI-LC...> 6/15/2009

BC 00215

Riley, Terri Sex: F BD: 03/23/1966 MR#: 1246660

Print this Page  
PT#: 15178578

HIS Discharge Summaries

Aug 14, 2005

THE UNIVERSITY HOSPITALS AND CLINICS  
THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER  
2500 NORTH STATE STREET  
JACKSON, MISSISSIPPI 39216-4505

DISCHARGE SUMMARY

PATIENT NAME: RILEY, TERRI  
BILLING NUMBER: 000013566156  
MEDICAL RECORD #: 124-66-60  
ADMIT DATE: 08/14/2005  
DISCHARGE DATE: 08/19/2005

ADMISSION DIAGNOSIS: GASTROPARESIS.

DISCHARGE DIAGNOSIS: GASTROPARESIS, STATUS POST GASTRIC PACEMAKER.

CONSULTATIONS:

1. PAIN MANAGEMENT.
2. ANESTHESIA.
3. GENERAL SURGERY.
4. WILLIAM ALEXANDER ROCK, M.D., PATHOLOGY, FOR COAGULATION WORKUP.

PROCEDURE: PERMANENT GASTRIC STIMULATOR PLACEMENT BY GENERAL SURGERY.

HISTORY OF PRESENT ILLNESS: THIS IS A 39-YEAR-OLD WHITE FEMALE WITH A HISTORY OF GASTROPARESIS WHO IS ADMITTED FOR PERMANENT GASTRIC STIMULATOR DEVICE PLACEMENT ON AUGUST 15, 2005. MS. RILEY HAS PROBLEMS WITH ABDOMINAL DISCOMFORT AND OCCASIONAL PROBLEMS WITH NAUSEA, THOUGH SHE HAS BEEN ON REGLAN AND ZELNORM. SHE STATES THAT FOR THE MOST PART, SHE TAKES LIQUIDS AND SOFTER FOOD WITHOUT MUCH DIFFICULTY, BUT SOLID FOODS CONTINUE TO GIVE HER ISSUES WITH ABDOMINAL DISCOMFORT. SHE DENIES ANY VOMITING AT THE PRESENT TIME WHILE ON ZELNORM AND STATES THAT IT HAS BEEN BETTER THAN REGLAN. THE PATIENT DENIES ABDOMINAL PAIN AND GI BLOOD LOSS SYMPTOMS.

REVIEW OF SYSTEMS: NEGATIVE.

PAST MEDICAL HISTORY: GASTROPARESIS.

FAMILY HISTORY: NONCONTRIBUTORY.

SOCIAL HISTORY: OCCUPATION: NOT EMPLOYED. NO TOBACCO OR ALCOHOL USE AT THE PRESENT TIME. NO ILLICIT DRUG USE.

MEDICATIONS: AS MENTIONED BEFORE, THE PATIENT HAS BEEN ON ZELNORM 12 MG DAILY PRIOR TO WHEN SHE WAS ON REGLAN.

ALLERGIES: NONE KNOWN.

PHYSICAL EXAMINATION:

CONSTITUTIONAL: TEMPERATURE 98.1 DEGREES, PULSE 72, BLOOD PRESSURE 96/67,  
RESPIRATORY RATE 20.  
APPEARANCE: NO ACUTE DISTRESS.

<http://oasgold.umc.edu/a0a6-ntap-bin/webofch.exe/PRD/2?KEY=PT0002INVISIONPI-LC...> 6/15/2009

EYES: NO SCLERAL ICTERUS. PUPILS WERE EQUAL, ROUND AND REACTIVE TO LIGHT.

EARS, NOSE, MOUTH AND THROAT: CLEAR OROPHARYNX, WITHIN NORMAL LIMITS HEARING.

NECK: TRACHEA MIDLINE, NORMAL APPEARANCE AND MOVEMENTS.

RESPIRATORY: CLEAR TO AUSCULTATION AND PALPATION, SYMMETRICAL CHEST EXPANSION.

CARDIOVASCULAR: NORMAL SOUNDS, NO MURMURS, GALLOPS OR RUBS, NO EDEMA.

ABDOMEN: NO TENDERNESS, NO HEPATOSPLENOMEGALY.

LYMPHATIC: NO CERVICAL OR SUPRACLAVICULAR ADENOPATHY.

MUSCULOSKELETAL: NORMAL GAIT, NO CLUBBING, NORMAL RANGE OF MOTION OF ALL 4 EXTREMITIES.

SKIN: NO RASH OR ULCERS, NO NODULES.

NEUROLOGICAL: NORMAL CRANIAL NERVES, NORMAL REFLEXES.

PSYCHIATRIC: ALERT AND ORIENTED TO PERSON, PLACE AND TIME, INTACT MEMORY.

INITIAL LAB REVIEW: CBC: WHITE COUNT 6800, HEMATOCRIT 36.5, PLATELETS 206,000. CHEM-8: SODIUM 141, POTASSIUM 3.6, CHLORIDE 102, CO2 28, BUN 6, CREATININE 0.8, GLUCOSE 151, CALCIUM 9.6. PT 12.5, PTT 26.1. NEGATIVE PREGNANCY TEST.

BRIEF HOSPITAL COURSE: THE PATIENT WAS ADMITTED TO THE GENERAL SURGERY SERVICE INITIALLY. SHE WAS SCHEDULED FOR A GASTRIC SIMULATOR PLACEMENT THE FOLLOWING DAY. SHE WAS GIVEN A REGULAR DIET AND THEN MADE N.P.O. AFTER MIDNIGHT. THE PATIENT TOLERATED THE SURGICAL PROCEDURE WELL WITH SOME POSTOPERATIVE CRAMPING AND ITCHING WHICH WAS FELT TO BE SECONDARY DUE TO HER PAIN MEDICATION. PAIN MANAGEMENT WAS CONSULTED AND THE PATIENT'S MORPHINE PCA WAS CHANGED TO A DILAUDID PCA WITH SOME RELIEF OF HER ITCHING. THE PATIENT'S CRAMPING IMPROVED ON POSTOPERATIVE DAY #2. SHE REMAINED TENDER IN HER RIGHT UPPER QUADRANT EPIGASTRIC AREA NEAR WHERE THE STIMULATOR HAD BEEN PLACED AND HER WOUND REMAINED CLEAN, DRY AND INTACT THROUGHOUT. THE PATIENT WAS GIVEN BENADRYL FOR HER ITCHING WITH GOOD IMPROVEMENT. THE PATIENT WAS SWITCHED TO P.O. PERCOCET THE NIGHT PRIOR TO HER DISCHARGE WITH GREAT RELIEF OF HER ITCHING AND HER DILAUDID PCA WAS DISCONTINUED. ON AUGUST 19, 2005, THE PATIENT WAS DEEMED FIT FOR DISCHARGE WITH THE FOLLOWING ORDERS.

DISCHARGE ORDERS:

1. DISCHARGE PATIENT TO HOME.
2. DIAGNOSIS: GASTROPARESIS, STATUS POST GASTRIC PACEMAKER.
3. CONDITION: STABLE.
4. DIET: REGULAR.
5. ACTIVITY: AS TOLERATED.
6. MEDICATIONS: PERCOCET 5/325, 1-2 TABLETS P.O. Q.6 H. P.R.N. PAIN, PHENERGAN 12.5 MG P.O. Q.6 H. P.R.N. NAUSEA.
7. FOLLOW-UP IS WITH DR. THOMAS ABELL WITH THE GI CLINIC AND DR. ABELL WILL SCHEDULE THIS.

ADDENDUM: THE CONSULT TO DR. ROCK FOR THE COAGULATION WORKUP YIELDED COMPLETELY NORMAL COAGULATION STUDIES.

ELECTRONICALLY AUTHENTICATED BY  
THOMAS L. ABELL, M.D. 09/01/2005 09:12

Dictated by: SAMUEL C. THIGPEN, M.D.

<http://oasgold.unc.edu/a0a6-ntap-bin/wcbcfch.exe/PRD/2?KEY=PT0002INVISIONPI-I.C> 6/15/2009

D: 06/19/2005  
T: 06/19/2005 10:44 A  
1920851/000878922

CC: THOMAS L. ABELL, M.D.

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<http://oasgold.umc.edu/a0a6-ntap-bin/webcfch.exe/PRD/2?KEY=PT0002INVISIONPI-LC...> 6/15/2009

Riley, Terri

Sex: F

BD: 03/23/1966

MR#: 1246660

 Print this Page  
PT#: 15178578

HIS Operative Notes

Dec 10, 2007

THE UNIVERSITY HOSPITALS AND CLINICS  
THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER  
2500 NORTH STATE STREET  
JACKSON, MISSISSIPPI 39216-4505

## OPERATION RECORD

Patient Name: RILEY, TERRI PAIGE  
Billing Number: 000014839607  
Medical Record #: 124-66-60  
Date of Birth: 03/23/1966  
Date of Surgery: 12/10/2007

ATTENDING SURGEON: ROBERT SCHNIEG, JR., M.D.

RESIDENT SURGEON: Jason Allen Payne, M.D.

ANESTHETIST: John D. Current, M.D.

## ANESTHESIA:

1. General anesthesia via oral endotracheal tube.
2. Local infiltration with 0.5% bupivacaine with epinephrine, total of 30 mL used.

## FIRST ASSISTANT:

## OPERATION:

1. Gastrointestinal electrical stimulation (GES) pacemaker box replacement.
2. Gastric myoelectric activity recordings

## PREOPERATIVE DIAGNOSES:

1. Gastroparesis, idiopathic, non diabetic, medication refractory, with good prior permanent gastroelectrical stimulation system (GES) response.
2. Nausea and vomiting.
3. Malfunction of GES system (dead box).

## POSTOPERATIVE DIAGNOSES:

1. Gastroparesis, idiopathic, non diabetic, medication refractory, with good prior permanent gastroelectrical stimulation system (GES) response.
2. Nausea and vomiting.
3. Malfunction of GES system (dead box).

INDICATIONS FOR PROCEDURE: Terri Riley is a 41-year-old Caucasian female with a history of idiopathic medication-refractory, non diabetic gastroparesis. She underwent gastroelectrical stimulation system implantation on August 15, 2005, by Dr. Salameh here at University. This provided excellent relief of her gastroparetic symptoms. She has now had complaint of a several-month time return of her gastroparetic symptoms including nausea and vomiting. Upon attempts at interrogation, the GES system is not responding.

The diagnosis of a malfunction of the patient's gastroelectrical stimulation system because of probable battery failure or "dead box syndrome" was made. Replacement of the GES box was recommended. The procedure, risks, benefits and alternatives were discussed with the patient. Her questions were addressed. She appeared to understand, and requested to proceed with operation as above.

**PROCEDURE DETAILS:** The patient was brought to the surgical suite on December 10, 2007, and placed in supine position on the operating table. After the uneventful induction of adequate general anesthesia, the patient was orally intubated. Ancef was given for perioperative antibiotic coverage. Plexipulse boots were applied for deep vein thrombosis prophylaxis.

The abdomen was prepped and draped in a standard sterile fashion with the use of an Ioban drape. Anatomic landmarks were identified including the patient's prior epigastric-midline incision and the palpation subcutaneous box in the right upper quadrant. Local infiltration anesthesia was performed by the surgical team in a field block fashion about the box. A transverse right upper quadrant incision was then made over the box and dissection carried down with electrocautery to the level of the pseudocapsule surrounding the box. Note was made that several leads were coiled on top and superficial to the box. These were dissected free. The box was delivered into the surgical field from the wound. The box was grossly intact. The leads were detached from the box and the box was delivered off the table to be sent to the manufacturer for fault analysis.

The wound was examined. The lead portions that were within the fibrous pseudocapsule were freed up for several inches. The inferior aspect of the GES pseudocapsule pocket was opened to allow the box to be relocated slightly more inferiorly. Of note, a third lead which was not connected was present within the surgical field.

The leads which had been removed from the box were then connected with sterile alligator clips to a biomedical grade physiologic recorder. Dr. Abell's team performed gastric myoelectric activity recordings for about 10 minutes, obtaining an excellent quality of signal.

A new gastroelectrical stimulation system box was then brought onto the field (Medtronic Enterra model, serial #NHV102432H). Leads were inserted into the box and secured in standard fashion. The box was then placed in the subcutaneous pocket with the leads coiled deep to the box. The box was interrogated and had excellent impedances.

The wound was copiously irrigated. Hemostasis was excellent. The surgical incision was then closed in layers with multiple interrupted 3-0 Vicryl sutures, followed by 4-0 Monocryl subcuticular sutures, then Mastisol and Steri-Strips.

At this point the box was again interrogated. Final impedances were: Unipolar #2 = 292 ohms; unipolar #3 lead = 342 ohms; bipolar leads = 511 ohms.

A dry sterile dressing was applied to the surgical wound. The drapes were removed. The patient was awakened from anesthesia and taken to the recovery room in stable condition. She tolerated the operation well.

**NOTE FROM DR. SCHMIEG:** As the attending surgeon I was present for and

Riley, Terri

Sex: F

BD: 03/23/1966

HR#: 1246660

Print this Page  
PT#: 15178578

## GASTRIC IMAGING

Aug 23, 2007 11:30

\*\* FINAL \*\*

NUC 0026 - GASTRIC EMPTYING IMAGING - Aug 23 2007  
NUCLEAR MEDICINE GASTRIC EMPTYING STUDY  
08/23/07 0730 hours

## CLINICAL HISTORY:

41-year-old female with non diabetic gastroparesis.

## FINDINGS:

Previous: 07/25/06

The patient was administered orally a 1.1 mCi dose of Tc99m labeled sulfur colloid in solid egg beater meal. Serial anterior and posterior gastric imaging was performed for four hours in upright position and time activity curve was generated with geometric mean. There is 53% retention at 1 hours, 26% retention at 2 hours and 5% at 4 hours. Distribution of activity in the stomach and bowel is otherwise unremarkable.

## IMPRESSION:

Normal radionuclide solid gastric emptying study. This is improved from prior examination 07/25/06.

VIJAYAKUMAR VANI, M.D./SUSAN ELIZABETH SHAMBURGER, M.D.  
499979/306

I certify the accuracy of this report on the basis of my own personal observations and interpretation

Read by: SUSAN ELIZABETH SHAMBURGER 007536 on Aug 23 2007 3:11P

Transcribed by: MT3 on Aug 23 2007 3:11P

Signed by: DR. VANI VIJAYAKUMAR on: Aug 23 2007 3:20P

Jun. 18. 2009 2:53PM

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No. 7904 P. 3



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Irvin D. Fleming, MD, FACS

May 19, 2009

Terry L. Jackson, Jr., M.D.  
8000 Wolf River Blvd., Suite 200  
Germantown, TN 38138

RE: TERRI P. RILEY

Dear Terry,

Today, I had the pleasure of meeting Ms. Riley in the office. As you will recall, she is a very pleasant, 43-year-old female with recurrence of her gastroparesis symptoms after the expiration of a gastric pacemaker battery. I've had a pleasant discussion with her today regarding the technique involved with changing a battery. I've also discussed the nature and frequency of her symptoms with her at length. I agree that she will benefit from a new battery, and we are working toward getting her on the operative schedule for this to be done in the near future.

I appreciate the privilege of seeing your patients in consultation.

Sincerely,

William C. Gibson, M.D.

WCG:mcc

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BC 00617



# Memphis Gastroenterology Group

www.memphisingastro.com

May 19, 2009

BlueCross BlueShield

Re: Terri Paige Riley  
DOB: 03/23/1966  
Our Chart #130803s

To Whom It May Concern:

Ms. Riley has been a patient of ours for some time and has been treated for gastroparesis with a gastric pacer. This has afforded her a markedly improved lifestyle and the ability to maintain both her activities at home with her family and also her activities at work with full gainful employment.

Her gastric pacer battery is currently past its service life and needs to be changed. I know there have been potential issues in the past with coverage for gastric pacers through BlueCross BlueShield. If it is possible, please make an exception to this policy in assisting her with coverage for her pacer battery replacement with Drs. Abell in Jackson, MS or with Dr. Gibson in Memphis, TN.

If you have any questions or concerns, please do not hesitate to call our office.

Sincerely,

Terrence L. Jackson, Jr., M.D.

TLJ/me

JUL-20-2009 08:43

NORTHCENTRAL ELECTRIC

6628387121

P.01/01



Blue Cross &amp; Blue Shield of Mississippi

Jackson, Mississippi 39215-1045  
Telephone: (601) 932-5704  
www.bcbssms.com

Committed to a Healthier Mississippi.

July 16, 2009

James Riley  
331 Cascade FLS  
Collierville, TN 38017RE: Patient: Terri  
ID#: 868264547M

Dear Mr. Riley:

This letter is in response to your request for benefits for the replacement battery for Terri's gastric electrical stimulator.

Based on our review of the information provided and our Medical Policy guidelines, gastric electrical stimulation is considered investigational for the treatment of gastroparesis of diabetic or idiopathic etiology. Investigational services are excluded under your self-funded benefit plan. Therefore, benefits cannot be provided for the replacement battery for the gastric electrical stimulator.

Our Medical Policy is the formal written guidelines regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by currently available peer-reviewed scientific literature as well as with input from Mississippi physicians.

We value you as a customer and look forward to continuing to serve your health care needs. If you have any questions, or if we may assist you further, please contact our Customer Service Department at 1-800-942-0278.

Best of Health,

Ginny Williams  
Supervisor, Appeals and Correspondence

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company,  
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TOTAL P.01

BC 00477

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## Track & Confirm

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- Delivered, July 24, 2009, 3:48 am, JACKSON, MS 39215
- Arrival at Unit, July 24, 2009, 3:47 am, JACKSON, MS 39201
- Processed through Sort Facility, July 23, 2009, 8:25 pm, JACKSON, MS 39201
- Processed through Sort Facility, July 23, 2009, 1:03 am, SPRINGFIELD, MA 01152
- Acceptance, July 22, 2009, 5:09 pm, WEST HARTFORD, CT 06107

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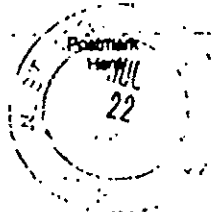
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7/28/2009 1 22

BC 00478



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with Chronic Illness, Inc.**

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(860) 674-1370 (phone)  
(860) 674-1378 (fax)  
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[www.advocacyforpatients.org](http://www.advocacyforpatients.org)  
[patient\\_advocate@sbcglobal.net](mailto:patient_advocate@sbcglobal.net)

July 22, 2009

Blue Cross Blue Shield of Mississippi  
ATTN: Appeals  
PO Box 1043  
Jackson, MS 39215

RE: Terri Palge Riley  
BCBS of MS ID no. YAQ868264547M  
SSN 425-35-4916  
Date of Service: To be Determined (prior authorization)  
Type of Service: Gastric electrical stimulation

Dear Sir or Madam:

I am writing on behalf of your insured, Terri Palge Riley, appeal your July 16, 2009 denial of a replacement battery for her gastric electrical stimulator. My HIPAA release and authorization is enclosed.

**I. Introduction**

Terri Palge Riley suffers from a severe case of gastroparesis, which is marked by stomach dysmotility. She underwent implantation of gastric electrical stimulation, also called Enterra Therapy, initially on August 15, 2005. It was paid for by the Electric Power Associations of Mississippi Group Benefits Trust ("the Plan"). Because of the severity of her illness, the battery on the device expired, and a new battery was installed on December 10, 2007. It, too, was paid for by the Electric Power Associations of Mississippi Group Benefits Trust. The second battery has now died, and she requires a battery replacement.

Without the device in operational condition, she suffers from nausea, vomiting, nutritional deficits, and abdominal pain. Ultimately, when her nutrition becomes too compromised, she would need a feeding tube and would have to take tube feedings for the rest of her life – a disabling, very expensive proposition – far more expensive than replacing the battery on the device she already has. With the device in operational condition, she has been able to work, eat, and lead an active lifestyle. The medical necessity of this battery replacement is clear. However, Blue Cross Blue Shield of Mississippi ("BCBS of MS") has taken the position in the past that the device is investigational. This conclusion is contrary to the medical literature and the standard of care. Indeed, since Ms. Riley already has the device implanted, it really cannot simply be left there non-functioning. And since we know that the device works to control her nausea and vomiting, it cannot be called experimental;

in fact, it works in this patient exactly as it should. Thus, we ask that you agree to cover the cost of a battery replacement.<sup>1</sup>

## II. Procedural History

On behalf of the Electric Power Associations of Mississippi Group Benefits Trust ("the Plan"), Blue Cross Blue Shield of Mississippi (BCBS of MS) first told Ms. Riley in writing that it would not make a determination of coverage before she had the device implanted. We then contacted Mr. Ty Harrell at the Electric Power Associations of Mississippi Group Benefits Trust. He asked us for Ms. Riley's medical records and other documentation, which we submitted to him on June 19, 2009. On June 23, 2009, Mr. Harrell informed the undersigned that he would be submitting the file for review by BCBS of MS. On July 15, 2009, the undersigned received a telephone call from Mr. Aaron Sisk of the Mississippi Insurance Department asking for the undersigned permission to contact BCBS of MS on Ms. Riley's behalf. The undersigned granted permission. Mr. Sisk was told by BCBS of MS by the Director of the Legal Department that, although he was unaware of Ms. Riley's case, he was aware of several requests for payment for gastric electrical stimulation, and that BCBS of MS takes the position that gastric electrical stimulation is investigational based on the work of Dr. Thomas Abell at the University of Mississippi. I enclose a letter from Dr. Abell stating that it is his opinion that gastric electrical stimulation has not been investigational for the past 10 years and, instead, that it represents the standard of care for patients with nausea and vomiting due to gastroparesis.

On July 16, 2009, BCSBS of MS wrote Ms. Riley and stated that it was denying her "request for benefits" to cover the battery replacement on the ground that it is investigational. (Copy enclosed). The letter failed to recite Ms. Riley's appeal rights, in violation of ERISA.<sup>2</sup> The undersigned called BCBS of MS to ask for appeal instructions and was told to send the appeal to the address on page one of this letter.

### III. The Plan Has Violated ERISA

Here, BCBS of MS has not provided full and fair review by failing to recite Ms. Riley's rights to appeal.

ERISA requires “full and fair review” by ERISA plan administrators. 29 U.S.C. § 1133. The statute sets out the following duties for plan administrators:

<sup>1</sup> We understand that you have more than one case pending involving Enterra Therapy and that you are concerned about setting a precedent. This case is special because Ms. Riley already has the device; you can't leave a dead foreign object in her body forever. We are aware that there are other Blue Crosses that cover this device under confidential settlements so as to avoid precedent. We would be willing to enter into such an agreement here. Since the settlements are confidential, I can't tell you which Blue Crosses use this process, but I'm sure you can ask your colleagues in other states. Of course, in other states, there are external appeals, and since we win most of those, we don't have to agree to confidentiality in those cases. (See enclosed copies of appeal decisions).

<sup>2</sup> The Electric Power Associations of Mississippi Group Benefits Trust is a self-funded plan that is not exempt from ERISA and, thus, it is under the jurisdiction of the U.S. Department of Labor and the federal courts.

~~CONFIDENTIAL~~

BCBS of MS  
July 22, 2009  
Page 3 of 10

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a *full and fair review* by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133 (emphasis added).

In addition, the Department of Labor has promulgated regulations that further clarify the nature and scope of full and fair review, as follows:

- (1) The specific reason or reasons for the denial;
- (2) Specific reference to pertinent plan provisions on which the denial is based;
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) **Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.**

29 C.F.R. § 2560.503-1(f) (emphasis added). "[A]n administrator abuses its discretion when it fails to afford a claimant a 'full and fair review' of its decision to deny her claim." *Soron v. Liberty Life Assurance Co. of Boston*, 318 F.Supp.2d 19 (N.D.N.Y. 2004) (citing *Crocco v. Xerox Corp.*, 137 F.3d 105, 108 (2d Cir.1998)).

Here, BCBS of MS failed in two ways to provide full and fair review.

First, BCBS of MS failed to recite the following rights:

You may receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to this request and an explanation of the scientific basis or clinical judgment that we relied upon in making our determination. This includes a copy of the internal rule, guideline, or protocol, if any, that we relied on in making the non-coverage decision for this request.

Second, BCBS of MS has failed to inform Ms. Riley of her right to appeal under the Plan.

"The core requirements of a full and fair review include 'knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.'" *White v. Airline Pilots Assoc Int'l*, No. 04 C 3307, 2005 WL 827001, \*11-12 (N.D. Ill. Apr. 8, 2005) (citing *Brown v. Retirement Comm. of Briggs & Stratton Retirement Plan*, 797 F.2d 521, 534 (7th Cir.1986)). "These requirements ensure that when a claimant appeals a denial to the plan administrator, he will be able to address the determinative issues and have a fair chance to present his case." *Id.*

To afford a plan participant whose claim has been denied a reasonable opportunity for full and fair review, the plan's fiduciary must consider any and all pertinent information reasonably available to him. The decision must be

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supported by substantial evidence. The fiduciary must notify the participant promptly, in writing and in language likely to be understood by laymen, that the claim has been denied with the specific reasons therefor. The fiduciary must also inform the participant of *what evidence he relied upon* and provide him with an opportunity to examine that evidence and to submit written comments or rebuttal documentary evidence. If the fiduciary allows third parties to appear personally, the same privilege must be extended to the participant.

*Grossmuller v. Int'l Union, United Automobile Aerospace and Agricultural Implement Workers of America*, 715 F.2d 853, 857-58 (3d Cir. 1983) (emphasis added). See also *Soron v. Liberty Life Assurance Co. of Boston*, 318 F.Supp.2d 19 (N.D.N.Y. 2004) (full and fair review requires that the fiduciary inform the claimant of the evidence the fiduciary relied on and an opportunity to submit comments and/or rebuttal).

Here, BCBS of MS has failed to include the above-quoted language in its noncoverage decision. Indeed, we have no idea whether Mr. Harrell did, in fact, forward everything we submitted to him in support of this claim for benefits, including some additional documents we sent him several days after our original June 19 submission. BCBS of MS has failed to inform us of our right to receive a copy of everything upon which it did rely. As a matter of law, the claimant is entitled to know what records the insurer was relying on and what was excluded. Thus, when the insurer said that it had relied on all available records, the insured had every reason to believe that certain records related to his Social Security benefits were part of the record. *Harden v. American Express Financial Corp.*, 384 F.3d 498, 500 (8<sup>th</sup> Cir. 2004). The insurer's failure to either inform the insured that it was not relying on certain documents **or to even obtain those records** constituted a "serious procedural irregularity." *Id.* (emphasis added). Thus, "although the insurer's decision would normally be subject to abuse-of-discretion review . . . we conclude that the district court should have applied a less deferential sliding-scale standard of review." *Id.* (citing *Shelton*, 285 F.3d at 642 (court may apply less deferential standard of review if plaintiff presents evidence demonstrating palpable conflict of interest or serious procedural irregularity that caused breach of plan administrator's fiduciary duty to plaintiff); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (1998) (adopting sliding-scale standard of review where less deferential standard is appropriate)). See also *Cannon*, 219 F.R.D. at 214 ("Finding out just what information [the fiduciary] had and why it acted as it did depends upon the medical notes provided to it, the exchange of correspondence, and the recollections of oral conversations.") (citing *Doe v. Travelers*, 167 F.3d 53, 58 (1st Cir.1999)).

Indeed, not only did BCBS of MS fail to offer Ms. Riley a copy of everything upon which it relied, but it also cites authority which is **not publicly available** in its Medical Policy on Gastric Electrical Stimulation. BCBS of MS cites to "Blue Cross Blue Shield Association policy # 7.01.73." We have no access to this document - it is not on the website of the Blue Cross Blue Shield Association or BCBS of MS - and BCBS of MS has not offered to provide it to us. BCSB of MS then cites to two documents written by Hayes, which is paid to write policies justifying insurance company denials, and whose documents are considered proprietary and, thus, based on our many years of experience doing health insurance appeals, we know that insureds may not be given copies of Hayes policies. Thus, three of the four documents upon which BCBS of MS relies are not publicly available.

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Gastric electrical stimulation (GES) is a medically accepted method of treatment for nausea and vomiting secondary to idiopathic or diabetic gastroparesis. On March 31, 2000, the Center for Devices and Radiologic Health (CDRH) of the FDA granted a Humanitarian Device Exception ("HDE") for Enterra Therapy. Letter from FDA to Medtronic granting HDE (March 31, 2000).<sup>4</sup> The FDA states that "[t]his device is indicated for the treatment of chronic, intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology." This – not treatment or cure of gastroparesis – is the intended use of Enterra Therapy. The CDRH does not grant a HDE without a finding that the benefits of the therapy exceed the risk, and the medical rationale for the use of the device is sound. 21 U.S.C. § 360j. The medical literature supports the FDA's finding.

In April 2006, the leading experts in the treatment of gastroparesis published a review of all of the literature relating to that treatment. This document contains "areas developed by consensus agreement where clinical research trials remain lacking . . . ." Abell, et al., "Treatment of gastroparesis: a multidisciplinary clinical review," 18 *Neurogastroenterol Motil* 263-283 (2006). This review was performed by gastroenterologists, nutritionists, diabetologists, surgeons, pain management and psychology experts all of whom care for gastroparetics. These "consensus opinions were formulated by the authors to facilitate management" of gastroparesis. The consensus opinion regarding gastric electrical stimulation concluded that studies show that roughly three-quarters of patients implanted with Enterra Therapy had reductions in nausea and vomiting and did not need further surgery or other invasive treatment of their gastroparesis. In the only sham-stimulation study, a statistically significant number of patients had less vomiting, and patients preferred the ON status to the OFF status by a "threefold margin." In the open phase of this study, patients reported a 76% reduction in vomiting at 12 months. The consensus found that in several other studies, Enterra Therapy "has been reported to improve nutritional status, limit the need for prokinetic and antiemetic medications, reduce the need for supplemental nutrition, decrease health-related costs" and improve the condition of diabetic gastroparetic patients. One study shows 26% reduction in nausea and 44% reduction in vomiting persisting for up to 10 years after implantation. The consensus found the research to be "encouraging."

Researchers at several centers have been conducting trials for a decade to test the effects of Enterra Therapy, and several articles have been published in peer-reviewed medical journals that are recent. In one of the early studies, researchers found that the severity and frequency of nausea and vomiting was significantly improved at three months and sustained at twelve months. Forster, et al., "Gastric Pacing is a New Surgical Treatment for Gastroparesis," 182 *American Journal of Surgery* 676 (Dec. 2001). Subsequently, a multi-center clinical trial demonstrated an 80% diminution in nausea and vomiting for 97% of the subjects. Additionally, these results were corroborated by an average weight gain of 5.5% at one year. Abell, et al., "Gastric Electrical Stimulation in Intractable Symptomatic Gastroparesis," 66 *Digestion* 204 (Aug. 2002). Long-term follow-up data confirmed improvement by short term, intermediate, and long-term measures with follow up to five years. Abell, et al., "Gastric Electrical Stimulation for Gastroparesis Improves Nutritional Parameters at Short, Intermediate, and Long-Term Follow-up," 27 *Journal of Parenteral and Enteral Nutrition* 277 (2003).

<sup>4</sup> All documents referred to herein are enclosed.

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A recent study showed greatly decreased symptoms and hospitalizations for as long as three years. Lin, et al., "Symptom responses, long-term outcomes and adverse events beyond 3 years of high-frequency gastric electrical stimulation for gastroparesis," 18 *Neurogastroenterol Motil* 18-27 (2006). Yet another recent study conducted at USC Los Angeles showed that Enterra Therapy returned patients to normal oral nutritional intake, increased body mass index, and improved gastric emptying rates. Mason, et al., "Gastric Electrical Stimulation: An Alternative Surgical Therapy for Patients with Gastroparesis," 140 *Arch Surg* 841 (Sept. 2005).

Further, investigators also have released results of a randomized controlled double-blind crossover study involving 33 patients that demonstrated a statistically significant reduction in frequency of vomiting and improved quality of life in patients with intractable gastroparesis, and then additional results confirming these outcomes. Abell, et al., "Gastric Electrical Stimulation for Medically Refractory Gastroparesis," 125 *Gastroenterology* 421 (Aug. 2003); Abell, et al., "Gastric Electrical Stimulation for Gastroparesis Improves Nutritional Parameters at Short, Intermediate, and Long-Term Follow-up," 27 *Journal of Parenteral and Enteral Nutrition* 277 (2003).

A retrospective series in which demonstrated the long-term improvement of upper GI symptoms, nutritional status, glucose control, and reduced number of hospitalizations was demonstrated. Lin, et al., "Treatment of Diabetic Gastroparesis by High-Frequency Gastric Electrical Stimulation," 27 *Diabetes Care* 1071 (May 2004). The same investigators then went on in a retrospective study to demonstrate a statistically significant reduction in the use of prokinetic/antiemetic medications. Cutts, et al., "Is gastric electrical stimulation superior to standard pharmacologic therapy in improving GI symptoms, healthcare resources; and long-term healthcare benefits?" 17 *Neurogastroenterol Motil* 35 (2005). Most recently, a group of German researchers have reported the results of a prospective single center study in which improved metabolic control in subjects with diabetic gastroparesis was demonstrated by reduced HbA1c levels in patients being managed with GES. van der Voort, et al., "Gastric Electrical Stimulation Results in Improved Metabolic Control in Diabetic Patients Suffering from Gastroparesis," 113 *Exp Clin Endocrinol Diabetes* 38 (2005).

Finally, a study comparing GES to traditional pharmacological study showed that GES results in both improved GI symptoms and decreased costs. Cutts, et al., "Is gastric electrical stimulation superior to standard pharmacologic therapy in improving GI symptoms, healthcare resources, and long-term healthcare benefits?" 17 *Neurogastroenterol Motil* 35 (2005).

In short, the medical literature strongly supports the use of Enterra Therapy to treat nausea and vomiting secondary to gastroparesis.

In addition, Enterra Therapy is becoming the standard of care for nausea and vomiting secondary to gastroparesis. We enclose medical policies from several large insurers that recognize that Enterra Therapy is medically necessary in cases in which nausea and vomiting secondary to gastroparesis is refractory to drug therapies and is resulting in serious nutritional deficiencies, as is the case here. Furthermore, we enclose a Medicare bulletin listing all of the many insurance companies that have covered Enterra Therapy, along with decisions from both internal and external reviewers, including some for United Healthcare, that show that Enterra is being approved on a nearly routine basis. Note that the number of external appeals approving this device grows almost weekly;

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Independent reviewers are stating over and over that Enterra no longer can be treated as experimental or investigational, and that coverage must be granted. (See, e.g., MCMC external reviews under General Motors benefit plan; U.S. Office of Personnel Management overruling of Mail Handlers Benefit Plan).

Indeed, Medicare in Mississippi pays for Enterra Therapy. In its policy stating the reasons for its denial of coverage found on its website, BCBS of MS directs us to [www.msmedicare.com](http://www.msmedicare.com). However, upon searching that website for "gastric electrical stimulation," one receives a policy that states that Medicare **"will provide coverage for Insertion of the Gastric Electrical Stimulator for gastroparesis or gastric dumping that is unresponsive to other forms of medical management."** (Emphasis added). In other words, Medicare is paying for this device, contrary to BCBS of MS's assertion.

Thus, all of the materials submitted herewith, including much of the medical literature, weighs in favor of finding that Enterra Therapy is a medically accepted treatment for the nausea and vomiting secondary to gastroparesis.

#### V. GASTRIC ELECTRICAL STIMULATION IS MEDICALLY NECESSARY TO TREAT A POTENTIALLY LIFE-THREATENING CONDITION

Terri Paige Riley has suffered from Idiopathic gastroparesis for some time, with symptoms beginning in 2003. (4/27/2004 Dr. Jackson office notes). It is moderate to severe, and it is constant and persistent. (6/17/2009 Dr. Jackson office notes). She has obtained relief with gastric electrical stimulation, but has suffered severe nausea, vomiting, abdominal pain, and nutritional deficits without it. (6/17/2009 Dr. Jackson office notes).

Before having the gastric electrical stimulator implanted, Ms. Riley tried all medical regimens, including Reglan, Erythromycin (including intravenous administration), Zelnorm, and even Domperidone, which is not FDA approved and has to be obtained from Canada. (June 9, 2005, February 17, 2005, June 17, 2009 Dr. Jackson office note). She has taken Phenergan for nausea, but was unable to tolerate it. (10/14/2004 Dr. Jackson office note). Her diet was restricted to liquids and food supplements. (April 7, 2005 Dr. Jackson office note).

In June 2005, she sought treatment at the University of Mississippi, where a temporary gastric pacemaker was placed and she was able to eat a hamburger and chicken as a result. (June 9, 2005 Dr. Jackson office note). Her symptoms returned when the temporary device was removed.

Ms. Riley had a permanent gastric electrical stimulator implanted in August 2005 as treatment for her gastroparesis. (August 15, 2005 operative report). The costs of this procedure were covered after her case was reviewed by an outside panel of three physicians who concluded that the Plan should cover the device, which it did.

The device was an unqualified success. On September 22, 2005, she told her gastroenterologist, Dr. Jackson, that she was "doing much better." "She states that it feels like her food is no longer taking up residence in her stomach. She states that she has had no further issues with nausea or vomiting." She was able to discontinue her medications.

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There was objective evidence of the success of the device, as well. An August 23, 2007 gastric emptying study showed normal gastric emptying, which was a tremendous improvement over a June 21, 2004 study, which showed only 34% emptying after 90 minutes. August 2008 upper endoscopy showed that everything was normal except for evidence of chronic gastritis, which is to be expected due to her history. Although the device was required to be readjusted several times in response to symptoms, Ms. Riley was able to work and lead an active life, with adequate nutrition.

Dr. Thomas Abell at the University of Mississippi – perhaps the most important gastric motility expert in the United States – has followed Ms. Riley's case. He documented Ms. Riley's symptoms upon the failure of her first battery. On October 29, 2007, Dr. Abell stated that her fatigue and nausea had increased greatly over the preceding two weeks. When he interrogated the gastric stimulator (which he refers to as the box), he was unable to do so, thereby concluding that it was dead and the battery had to be replaced. Two months earlier, Dr. Abell documented the fact that her gastric emptying was improved, and he increased the electrical current from her device.

In December 2007, because the battery in the device had ceased functioning, a replacement battery was implanted, also covered due to medical necessity. (12/10/2007 operative report). It, too, provided relief. As recently as August 8, 2008, Ms. Riley was able to tolerate more foods. (Dr. Jackson office note).

Now, it appears that her battery is dead again, and needs to be replaced. It was interrogated on May 12, 2009 and was not responsive. (Dr. Jackson office note).

When functioning, the device has worked well to control the nausea and vomiting secondary to gastroparesis. (Gibson 5/19/2009 office note). However, Dr. Jackson has documented persistent, severe symptoms more recently, with the device not functional. "Associated symptoms include abdominal pain, dizziness, lightheadedness, loss of appetite, vomiting, weakness and constant relapsing nausea." (6/17/2009 office note). Dr. Jackson states that Ms. Riley has difficulty maintaining hydration, and is only taking 600-1000 calories per day. As Dr. Jackson puts it, "until the gastric pacer can be repaired, the issues with malnutrition, dehydration, pain, fatigue and such will continue to be an issue most likely requiring recurrent and extended hospitalizations." Her symptoms persist despite taking Compazine, Marinol, Domperidone, and Phenergan. However, "[s]he has not been able to keep up with her po [i.e., food, liquid by mouth] intake due to the N/V [nausea and vomiting]." (6/9/2009 Dr. Jackson office note). Indeed, on June 9, Dr. Jackson admitted Ms. Riley to the hospital for rehydration and IV Erythromycin, and she remained hospitalized for three days.

During the period from June 19, 2009, when Ms. Riley's records were submitted to the Plan, and the date of this letter, Ms. Riley was unable to work at all. She was given IV fluids, medication, and nutrition on an outpatient basis, and was hospitalized yet again for the better part of one week. (7/20/2009 Dr. Jackson office notes). Her doctors have now given her a choice between having the surgery regardless of BCBS of MS's position and having a port-a-cath inserted for better IV access because her veins are so weakened by her dehydration. In order to have the battery in the device replaced without the Plan's approval, Ms. Riley will have to withdraw the necessary funds from her 401(k) account and then file claims with BCBS of MS while this and any subsequent appeals are pending.

## VI. CONCLUSION

BC 00176

## Medical Records Copy

Printed: 9/8/2009 2:56:00 PM

Saint Francis Hospital  
Memphis

5959 Park Avenue Memphis, TN 38119



0001

## ADMITTING DIAGNOSIS

GASTROPARSIS

Organism	Uthptl	T	VAL	Qty	Blod	Med Ntry	Autops	TOTAL:
								DAYS STAY
								CONSULT

ACCT NO	SIN/ROOMED	LIN #	INR	ADMIT DATE	ADMIT TIME	DISCH DATE	DISCH TIME	AO	TYPE	IRG	VW	CDRSH	INBLGOU	REF CD	ISOL CD	FT/TP	CLINCD
028831600	11	00080900		07/31/2009	09:06	JUL 31 2009	23:59			56						OSD	OS
ADMITTING PHYSICIAN	DR #	ATTENDING PHYSICIAN	DR #	PRIMARY CARE PHYSICIAN				DR #	ADM GROUP								
GIBSON, WILLIAM	7650	GIBSON, WILLIAM	7650	BREWER, R MICHAEL				303	GIBSON, WILLIAM								

PATIENT LAST NAME FIRST MI	ALSO KNOWN AS (NAMES)		DOB	AGE	SEX	RACE	KG	LANGUAGE
RILEY, TERRI P	RILEY TERRI, TERRI		03/23/1966	43	F	WHI	M	ENGLISH
PATIENT ADDRESS	CITY	STATE	ZIP	COUNTY	DATE STATUS			
331 CASCADE FALLS	COLLIERVILLE	TN	38017-2345	01-	1			
HOME PHONE NUMBER	SSN #	PRV ADMT	REASON	CONATION CODES	OCCUR		OS DAYS	
(801)861-3559	425-35-4816		BP					
PATIENT EMPLOYER	OCCUPATION	LENGTH EMPLOYMENT	WORK PHONE NUMBER					
AOC, LLC		1	(662)495-2151					
PATIENT EMPLOYER ADDRESS	CITY	STATE	ZIP					
175 COMMERCE RD	COLLIERVILLE	TN	38017					
PATIENT WORK LOCATION	FROM	TO						

GUARANTOR LAST NAME FIRST MI	SEX	PT RELATION	SSN #	HOME PHONE NUMBER	EMP TYPE
RILEY, TERRI P	F	SELF	425-35-4816	(801)861-3559	
GUARANTOR ADDRESS	CITY	STATE	ZIP	COUNTY	
331 CASCADE FALLS	COLLIERVILLE	TN	38017-2345	US	
GUARANTOR EMPLOYER	OCCUPATION	LENGTH EMPLOYMENT	WORK PHONE NUMBER		
AOC, LLC			(662)495-2151		
GUARANTOR EMPLOYER ADDRESS	CITY	STATE	ZIP		
175 COMMERCE RD	COLLIERVILLE	TN	38017		
GUARANTOR WORK LOCATION					

EMERGENCY DATA LAST NAME FIRST MI	HOME PHONE NUMBER	WORK PHONE NUMBER	PTREL				
RILEY, JIM	(801)299-5022		SPOUSE				
INSURANCE 1 NAME	INSURANCE 1 ADDRESS 2	CONTRACT/POLICY #	PRE AUTHORIZATION #	FINCLASS	PLAN NUMBER	TYPE	COB
BC OUT OF STATE PPO		YAC868264547M	NPR OPS OBS	80	033		
INSURANCE 1 ADDRESS	CITY	STATE	ZIP	INSURANCE 1 PHONE #	SUB DOB		
PO BOX 180150	CHATTANOOGA	TN	37401	(800)257-5825	07/12/1967		
SUBSCRIBER NAME LAST, FIRST, MI	PATIENT RELATION	GROUP NAME	GROUP NUMBER				
RILEY, JAMES	SPOUSE	N CENTRAL ELECTRIC POWE	730230				
INSURANCE 2 NAME	INSURANCE 2 ADDRESS 2	CONTRACT/POLICY #	PRE AUTHORIZATION #	FINCLASS	PLAN NUMBER	TYPE	COB
INSURANCE 2 ADDRESS	CITY	STATE	ZIP	INSURANCE 2 PHONE #	SUB DOB		
SUBSCRIBER NAME LAST, FIRST, MI	PATIENT RELATION	GROUP NAME	GROUP NUMBER				

ACCIDENT LOCATION	ACCIDENT DATE	ACCIDENT TIME	ACCIDENT TYPE	ATTEND	ACCOMPANIED BY
				2	

CONSENT AND/OR CONSENT	PROCEDURE DATE	POLICY #	DATE NOTIFIED	POLICE DEPARTMENT NOTIFIED

REMARKS	CONTINUED REMARKS
	7/31 GASTRIC PACEMAKER BATTERY EXCHANGE

ACCT # 028831600



028831600

PRINTED BY: MClemmons

DATE

9/9/2009

BC 00505

ISSUE DATE: 8/03/09 ST. FRANCIS HOSPITAL REPORT-TD: ND0525  
 ISSUE TIME: 9:30 PAGE: 1  
 PATIENT NAME: RILEY, TERRI P MR#: 989930 ADMIT: 07/31/09  
 STREET: 331 CASCADE FALLS ACCT#: 028831600 DISCH: 07/31/09  
 CITY: COLLIERVILLE BIRTHDATE: 3/23/66 SEX: F  
 STATE: TN ZIP: 38017 PHONE: (901) 861-3559  
 \*\*DISPOSITION INFORMATION\*\*

CODE DESCRIPTION  
 01 HOME

## \*\*PHYSICIAN INFORMATION\*\*

ATTENDING:

GIBSON, WILLIAM

ADMITTING:

GIBSON, WILLIAM

REFERRING:

BREWER, R MICHAEL

PRINCIPAL SURGEON:

GIBSON, WILLIAM

## \*\*ICD-9-CM DIAGNOSIS INFORMATION\*\*

CODE DESCRIPTION  
 536.3 GASTROPARESIS

## \*\*ICD-9-CM PROCEDURE INFORMATION\*\*

CODE DESCRIPTION  
 86.96 INSERT/REPL OTH NEUROST

## \*\*ICD-9-CM REASON FOR VISIT INFORMATION\*\*

CODE DESCRIPTION  
 536.3 GASTROPARESIS

## \*\*CPT4 CODE INFORMATION\*\*

CODE DESCRIPTION  
 64590 INSERT/REDO PN/GASTR STIMUL

## \*\*CHARGE BASED HCPCS CODE\*\*

CODE DESCRIPTION  
 J2550 Promethazine hcl injection  
 J3490 Drugs unclassified injection  
 J3490 Drugs unclassified injection  
 J2550 Promethazine hcl injection  
 J3490 Drugs unclassified injection  
 J3490 Drugs unclassified injection  
 S0020 Injection, bupivacaine hydro  
 J3490 Drugs unclassified injection  
 J3490 Drugs unclassified injection  
 J3490 Drugs unclassified injection  
 J7120 Ringers lactate infusion

\*NODESC\*

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J3590 Unclassified biologics

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DATE

9/9/2009

BC 00506

ISSUE DATE: 8/03/09 ST. FRANCIS HOSPITAL REPORT-ID: ND0525  
 ISSUE TIME: 9:30 PAGE: 2  
 PATIENT NAME: RILEY, TERRI P MR#: 989930 ADMIT: 07/31/09  
 STREET: 331 CASCADE FALLS ACCT#: 028831600 DISCH: 07/31/09  
 CITY: COLLIERVILLE BIRTHDATE: 3/23/66 SEX: F  
 STATE: TN ZIP: 38017 PHONE: (901) 861-3559

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C1767 Generator, neuro non-recharg

81025 \*NODESC\*

36415 ROUTINE VENIPUNCTURE

\*NODESC\*

\*NODESC\*

\*NODESC\*

\*NODESC\*

\*NODESC\*

J1200 Diphenhydramine hcl injectio

J1170 Hydromorphone injection

J3010 Fentanyl citrate injectio

J1170 Hydromorphone injection

\*NODESC\*

\*\* END OF REPORT \*\*

0015 2 2503 000

PRINTED BY: MClommons

DATE 9/9/2009

BC 00507



**Saint Francis Hospital**  
Memphis



879-31

**SHORT SERVICE RECORD**

Chief Complaint: Crohn's

History of Present Illness: 13yo female with history change for recurrent symptoms

Significant Past Medical History/Previous Surgery: Gastric band

Allergies: Morphine, cocaine, Zofran

Health History (circle if applies and explain below)			
Kidney Disease	Heart Disease	Lung Disease	<u>Crohn's Disease</u>
Neuro Disorder	Cancer	Steroid Use	Tobacco Use
		Diabetes	Drug Abuse
		Alcohol	OTC/Herbals
Mental Illness	Mental Handicap		
PEDs only: Prematurity Developmental Delay Immunizations Up to Date			
Exposure to Communicable disease within past 2 weeks			
Physical Examination ***Must be documented***			
	WNL	Not Pertinent	Findings
General	✓		
HEENT	✓		
Chest	✓		
Heart	✓		
Abd/GI	✓		
Extremities	✓		
Neuro	✓		
GYN/GU		✓	
System review			
	WNL	Not Pertinent	Findings
General			<u>daily nausea</u>
HEENT	✓		
Chest	✓		
Heart	✓		
Abd/GI	✓		
Extremities	✓		
Neuro	✓		
GYN/GU	✓		
Home Medications (Include OTC / Herbals) (Include the Dose and number of times taken per day)			
<u>List reviewed</u>			

If H&P performed within 30 days before admission, patient re-assessed within 24 hours prior to surgery H&P update performed:  
 There have been no significant changes in the patient's condition since the date of the previous assessment  
 The following changes have occurred since the date of the previous assessment:

Date: 7/31 Time: 10:56 Physician Signature: WC Gibson

Discharge Information: Hospital Course (include discharge condition, instructions, follow-up)

Final Diagnosis:

D/C meds:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Short Service Form  
Page 1 of 1



028831600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

R3/08

33252 2006082

PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00508

SAINT FRANCIS HOSPITAL  
5959 PARK AVENUE  
MEMPHIS, TN 38119

OPERATIVE NOTE

Patient: RILEY, TERRI P  
Med Rec#: 000989930  
Encounter#: 28831600  
Physician: GIBSON, WILLIAM  
Admit: 07/31/2009  
Disch: / /  
Job Number: 044176360

DATE OF PROCEDURE: 07/31/2009

PREOPERATIVE DIAGNOSIS: Idiopathic gastroparesis.

POSTOPERATIVE DIAGNOSIS: Idiopathic gastroparesis.

PROCEDURE: Gastric pacemaker battery exchange.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Less than 25 cc.

INDICATIONS FOR PROCEDURE: The patient is a 43-year old female with a long history of idiopathic gastroparesis. She originally had her gastric pacemaker placed in 2005 with good results for 2 years. Her battery subsequently deteriorated and when it was replaced in 2007, she continued to have good results with virtual absence of gastroparesis symptoms for 2 more years. In recent weeks, her battery has again deteriorated and her symptoms have recurred. She desired battery exchange for relief of her symptoms with activity of her pacemaker again. The risks, benefits and alternatives of the operation were explained to her preoperatively. She understood and wished to proceed.

FINDINGS AT OPERATION: The old battery was easily removed and the pocket had a very normal appearance with 2 leads intact and scarred into the fibrous capsule. When the new pacemaker pulse generator was placed, impedance was found to be excellent with a level of 592 ohms. The pacemaker was easily reprogrammed and activated.

DESCRIPTION OF PROCEDURE: After informed consent was obtained, the patient was taken to the operating room and placed on the operating table in the supine position. Adequate general endotracheal anesthesia was induced and the abdomen was prepped and draped in the normal sterile fashion. A final time-out was conducted and Ancef was given within 1 hour of operation for prophylactic use only and will be discontinued. Sequential compression devices were used for venous thromboembolism prophylaxis. The transverse incision overlying the existing

Page: 1

00057 5000437

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DATE 9/9/2009

BC 00509

SAINT FRANCIS HOSPITAL  
5959 PARK AVENUE  
MEMPHIS, TN 38119

OPERATIVE NOTE

Patient: RILEY, TERRI P  
Med Rec#: 000989930  
Encounter#: 28831600  
Physician: GIBSON, WILLIAM  
Admit: 07/31/2009  
Disch: / /  
Job Number: 044176360

pulse generator was re opened and Bovio electrocautery was used to divide the fibrous capsule and expose the surface of the pulse generator. It was easily removed from its pocket and the leads were seen to be coiled in a good anatomic position underneath the pulse generator. The leads were released from the old pulse generator and it was removed from the field and replaced by a new one.

The leads were re-placed into the new pulse generator and tightened with the screwdriver. The pacemaker was then interrogated and found to have an acceptable impedance value and it was then reprogrammed and activated. Current voltage at 7.0 with a pulse width of 330. Its interval is 2 seconds on with 3 seconds off.

The wound was then irrigated with Kantrex-impregnated solution and meticulous hemostasis was assured. The wound was closed in 2 layers and dressed with Dermabond after the pulse generator had been returned into the pocket and secured with a pair of Prolene sutures. The patient is currently being awakened in the operating room and transferred to the recovery room as expected shortly. She remains in good condition and all sponge and instrument counts are correct.

WILLIAM GIBSON, MD

TIME: \_\_\_\_\_  
DATE: \_\_\_\_\_

D: 07/31/2009 12:07 CST  
T: 07/31/2009 14:45 CST  
D#:00111296/JLG881252

Page: 2

Authenticated by WILL GIBSON, MD On 8/03/09 9:17:30 AM Central Time

08/03/09 09:08:03

PRINTED BY: MClommons

DATE

9/9/2009

BC 00510

SAINT FRANCIS HOSPITAL  
JUSTIN C. ADLER, M.D. DIRECTOR OF LABORATORY  
5959 PARK AVE., MEMPHIS, TENNESSEE

PAGE: 1

NAME: RILEY, TERRI P      DOB: 03/23/1966      AGE: 43Y      SEX: F  
MR: 989930      LOC: OPS      ACCT: 028831600  
ATT #: 7650      ADMIT: 07/31/2009      ADMIT DR:  
ATTEND DR: GIBSON, WILLIAM

## \*\*\*\*\* MISCELLANEOUS URINES \*\*\*\*\*

DAY: 1  
DATE: 07/31/09  
TIME: 0923      NORMAL      UNITS  
URINE, HCG      NEGATIVE      NEG

RILEY, TERRI P  
08/04/2009      06:33  
00251 5308632

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DATE 9/9/2009

BC 00511

END OF REPORT

03/25/09 09:08/35

PRINTED BY: MClemmons

DATE

9/9/2009

BC 00512



## OUTPATIENT SERVICES POST OPERATIVE INSTRUCTIONS



\*679-14\*

YOUR ARE URGED TO FOLLOW CAREFULLY THE FOLLOWING INSTRUCTIONS:

- ☒ Make an appointment to see your physician  
In/on at St. Francis
- ☒ Observe the operative areas for signs of excessive bleeding. (slow general oozing that saturates the dressing completely or frank bright red bleeding.) In either case, apply pressure to the area, elevate it if possible and contact your physician at once!
- ☐ Observe the affected extremity for circulation or nerve impairment:
- |                      |                |
|----------------------|----------------|
| Change in color      | Coldness       |
| Numbness or tingling | Increased pain |
- If any of these signs or symptoms are present, call your physician at once!
- ☒ Observe the operative areas for signs of infection:
- |                |           |
|----------------|-----------|
| Increased pain | Swelling  |
| Redness        | Foul odor |
- These signs and symptoms usually become apparent in 36 to 48 hours. If present, contact your physician.
- ☒ Keep the operative areas clean and dry. Do not remove the dressing unless instructed to do so by your physician.  
OK to Shower tomorrow
- ☐ Keep the operative site elevated for the next 12 to 24 hours.
- ☐ Apply ice to the operative site as directed.
- ☐ Avoid stress to the suture line such as pulling, pushing, etc.
- ☐ May change the nasal tip dressing as needed and as demonstrated.
- ☐ Avoid sneezing or blowing the nose.
- ☐ Keep water out of the ears.

### SEDATION:

If you had general anesthesia or local anesthesia with sedation, please pay particular attention to the following instructions:

1. Do not drink alcoholic beverages, including beer for 24 hours. Alcohol enhances the effects of anesthesia and sedation.
2. Do not drive a motor vehicle, operate machinery or power tools for 24 hours. If a child, no bicycle riding, skateboard, gymnastics, etc., for 24 hours.
3. Do not make important decisions or sign important papers for 24 hours.
4. You may experience lightheadedness, dizziness and sleepiness following surgery. Please **DO NOT STAY ALONE**. A responsible adult should be with you for this 24 hour period.
5. Rest at home with moderate activity as tolerated. It may not be necessary to go to bed; however, it is important to rest for 24 hours following general anesthesia.
6. Progress slowly to a regular diet unless your physician has instructed you otherwise. Start with liquid such as soft drinks, then soup and crackers gradually working up to solid foods.
7. Certain anesthetics and pain medications may produce nausea and vomiting in certain individuals. If nausea becomes a problem at home, call your physician. In the meantime, rest or sleep on your side to avoid accidentally inhaling material that you may vomit.

### POST OPERATIVE TELEPHONE CALL:

A representative from the Outpatient Service Department may call you by telephone a few days after surgery. Do not be alarmed. This is a routine call to find out how you are progressing after your surgery.

### REGARDING MEDICATIONS:

1. If your physician ordered pain medication, take it as directed. Do not drive or operate machinery or power tools while taking this medication.
2. Check with your physician regarding medications which you were taking prior to surgery.

If you should experience difficulty in breathing, bleeding that you feel is excessive, persistent nausea or vomiting, any pain that is unusual, swelling or fever, please call your physician. If you find that you cannot contact your physician but feel that your signs and symptoms warrant a physician's attention, go to an Emergency Room which is closest to you.

### OTHER INSTRUCTIONS:

Follow up in 2 weeks

I hereby accept, understand, and can verbalize/demonstrate these instructions:

Witness: Patty Spiller

Patient or Guardian: [Signature]

Date: 7/5/9 Time: 1430

Relationship to Patient

FORM #679-14 Rev. 3/05  
MMS #44638

White - Chart  
Canary - Patient



028831600

DSO MR#0098930 DDB:03/23/1966  
RILEY, TERRI P 43 F  
DIBSON, WILLIAM 07/02/2009  
ST. FRANCIS HOSPITAL MEMPHIS

00000000000000000000

PRINTED BY: MCLemmon

DATE 9/9/2009

BC 00513

PATHOLOGY REPORT  
ST FRANCES HOSPITAL  
5959 Park Avenue  
Memphis, TN 38119  
(999) 123-4567

Print Date: 08/03/2009  
Print Time: 10:43:14

Discharge Date: 07/31/2009

Patient Name: RILEY, TERRI P  
Account No: 028831600  
NS: OS Room: -

MedRecNo: 000989930  
Admitted: 07/31/2009  
Doctor Name:

Sex: F  
DOB: 03/23/1966

Pathology: Tissue Request

Case# SC09-5010

Date Collected 07/31/2009 Collection Time 00:00

SURGICAL PATHOLOGY REPORT

Collected Date and Time 7/31/2009 00:00  
Received Date and Time 07/31/2009 00:00  
Accession Number SC09-5010  
Submitting MD WILLIAM GIBSON MD

DIAGNOSIS:

A. Neurostimulator explant:  
Neurostimulator explant, gross examination only.

Electronically signed by ALLEN D BERRY MD  
Verified: 8/3/2009 10:38  
dt/ADB

SPECIMEN SOURCE:

A: Neurostimulator explant

CLINICAL INFORMATION:

Battery depletion of gastric neurostimulator.

GROSS EXAMINATION:

A. Neurostimulator explant: Received is a metallic generating device that is 6.0 x 5.5 x 1.0 cm. On one surface is written Medtronic Enterra NHU102432H. Gross only.

an/EH

Patient Name: RILEY, TERRI P  
Pathology: Tissue Request

Page: 1

355157 50000000 PRINTED BY: McLemmons

DATE 9/9/2009

BC 00514



**Saint Francis Hospital**  
Memphis



1000-609

Patient Criteria	NPO	Rt. Meds	No Labs	HCG	EKG	K+	Glu	CBC/BMP	PT/INR	CXR	LFT	TSH (3, 4)
1. At least 8 hrs. prior to O.R.	*											
2. Takes reflux, ulcer, cardiac, antihypertensives, respiratory, and/or seizure meds, in A.M. of O.R. with sip of water.		*										
3. Healthy pediatric.			*									
4. Minor procedures under local anesthesia with IV sedation unless patient meets criteria in 6, 8, 10, 12, 16 or 18.			*									
5. Females of childbearing capability (day of surgery).				(*)								
6. Cardiac risk factors: CHF, CAD, PVD, HTN, MI, diabetes, ICD, pacemaker, 50 yrs. or older, hyperlipidemia, family Hx of MI under 50 y/o. A copy of an EKG done within 3 months of surgery is acceptable on stable patients with these risk factors.					*			*				
7. Chemo or radiation therapy within 1 yr.					*			*		*		
8. Smokes 15-pack year.					*					*		
9. Diuretics or dialysis (day of surgery).					*							
10. Accucheck on diabetics and patients undergoing heart surgery (day of surgery).							*					
11. On Antihyperthyroidism meds.												*
12. On Coumadin or Hx of bleeding disorders (day of surgery).									*			
13. Hx. of alcoholism, liver disease, morbid obesity, drug abuse, or on antilipid meds.											*	
14. General, regional, IV sedation, retinal bulbar block or taking weight reduction meds.								*				
15. Dyspnea at rest or acute respiratory distress.					*					*		
16. Chest discomfort since last cardiac workup, get previous EKG for comparison.												

Lab work must be within 30 days of procedure

Call Anesthesia at 3465 or 2100 regarding abnormal test results.

Nurse Signature: [Signature]

Date: 7/31/09

Time: 920

**OUTPATIENT SURGICAL  
PREOPERATIVE PROTOCOL**

Page 1 of 1



OPM MR#00989930 DOB: 03/23/1966  
RILEY, TERRI P 43 F  
DORSON, WILLIAM 07/13/2009  
SAINT FRANCIS HOSPITAL MEMPHIS

028831600

MR# DC

R12/07

00257 3003025

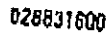
PRINTED BY: MClemmons

DATE

9/9/2009

BC 00515

No. 4107 P. 1/1



5959 Park Avenue  
Memphis, Tennessee 38119

Torn: Riley  
DB 3-23-66

### Addressograph

7.17.69

7/31

POOR ORIGINAL

7-20-68

7-3-0  
103

Medications dispensed in accordance with the hospital formulary system.

9/9/2009

BC 00516





**Saint Francis Hospital**  
Memphis



1000-212

PHYSICIAN'S ORDERS	PROGRESS RECORD
<input type="checkbox"/> In-Patient Admit <input type="checkbox"/> Observation Status <input checked="" type="checkbox"/> Return to Out-Patient Care <input checked="" type="checkbox"/> Discharge when OPS criteria met <p>To PACU, then SBS, then home  s/p gastric pacemaker battery exchange  stable  Diet as tolerated  Resume home meds  Discharge per  ok to shower beginning tomorrow.  F/U E in 2 weeks.</p> <p>HC Tilson</p> <p>3B  Tilson  Dr. Tilson  2/31/09  1320</p>	<p>Date: <u>7/31</u> Time: <u>12pm</u>  Surgeon: <u>W. Gibson</u>  Assistant(s): <u>J. Riley</u>  Anesthesia Provider: <u>Pakl</u>  Pre-Op Diagnosis: <u>Gastroparesis</u>  Procedure: <u>Gastric pacemaker battery change</u>  Findings: <u>Normal pocket.</u>  <u>Leads intact</u>  Specimen/Tissue: <u>Ø</u>  EBL: <u>&lt; 5cc</u>  Complications: <u>Ø</u>  Post-Op Diagnosis: <u>same</u>  Physician Signature: <u>HC Tilson</u>  Time: _____ Date: _____</p> <p><b>DO NOT USE ABBREVIATIONS</b>  Q.D., Q.O.D., MS, MSO4, U or IU, MgSO4, ug, zero after decimal point, no zero before decimal dose, A.S., A.D., A.U., O.S., O.O., O.U.</p>
Physician Signature: _____ Time: _____ Date: _____	

Medications dispensed in accordance with the hospital formulary system.

**Post Operative Progress Note**  
Page 1 of 1

R2/08



028831600

OPM MR#00989930 DOB:03/23/1966  
**RILEY, TERRIP F 43**  
GIBSON, WILLIAM 07/31/2009 -

MEMPHIS 3000000

PRINTED BY: MClemmons

DATE

9/9/2009

BC 00518



## ANESTHESIA ORDERS FOR PACU

1. PAIN:
  - ☒ Hydromorphone 0.5 to 1mg IV every 5 minutes PRN up to 2mg. *done*
  - ☐ Morphine 1 to 4mg IV every 5 minutes up to 15mg.
2. NAUSEA:
  - ☐ Ondansetron 4mg IV over 2 minutes; may repeat once after 30 minutes if no response.
  - ☒ Promethazine 12.5mg IV one dose only. *done*
3. ITCHING:
  - ☐ Diphenhydramine 12.5mg IV; may repeat in 10 minutes if needed. Max dose 25mg.
4. SHIVERING:
  - ☐ Meperidine 12.5mg IV; may repeat in 10 minutes. Max dose 25mg.
5. IV FLUIDS:
  - ☒ Maintain current IV fluids at TKO rate.
6. DIABETES:
  - ☐ Accucheck on arrival to PACU.
  - ☐ Treat according to Sliding Scale insulin protocol.
  - ☐ Notify MD/CRNA if blood glucose is less than 70mg or greater than 200mg.
  - ☐ Repeat accucheck in \_\_\_\_\_ minutes after any intervention.
7. HYPERTENSION: Treat with the following medications if SBP is greater than 160mmHg.
  - ☐ Labetolol 5 - 10mg IV; may repeat every 10 minutes. Max dose 40mg or HR is less than 60.
  - ☐ Hydralazine 10mg IV every 30 minutes. Max dose 20mg.
  - ☐ Metoprolol 1mg IV every 5 minutes. Max dose 5mg or HR is less than 60.
8. RESPIRATORY:
  - ☒ Administer oxygen per PACU policy.
  - ☒ Use the Respiratory Weaning Protocol.
  - ☐ ABG's in 30 minutes post extubation.
  - ☐ Albuterol aerosol treatment 2.5mg UD; may repeat in 30 minutes unless HR greater than 110.
  - ☐ Racialic Epinephrine aerosol treatment UD.
  - ☐ Call Anesthesia immediately if:
    - SAO<sub>2</sub> is less than 90%.
    - Respiratory rate is greater than 30/minute.
    - Any signs of respiratory distress.
9. DISCHARGE ORDERS:
  - ☒ Discharge from PACU when discharge criteria have been met.
  - Discontinue above orders 1 through 8 upon discharge from PACU.

MD/CRNA: *[Signature]*

Date: 7/3/09 Time: 12:30

## ANESTHESIA POSTOP ORDERS FOR INPATIENT UNITS

- ☐ If SAO<sub>2</sub> is less than 90% and no contraindication exists:
  - Give O<sub>2</sub> BNC at 2 to 4 liters/minute.
  - Monitor and record SAO<sub>2</sub> every 4 hours for 24 hours.

MD/CRNA: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Medication dispensed in accordance with the hospital formulary system.

Anesthesia PACU Orders  
Page 1 of 1

R6/07



028831800

OSD MA#00989930 DOB:03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2008  
JOINT TRAUMATIC SYSTEM

IR# DOB:

02:27 3403/09

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DATE 9/9/2009

BC 00519



# Saint Francis Hospital Memphis



\*601-709A\*

Patient has been instructed on medications as listed.

## Record of Home Medications and Herbal Supplements

Medication	Dose	Dose Schedule (frequency)	(✓) Medications to Continue During Hospitalization		
			Yes	No	
1 <u>Plavix</u>	<u>25-mg</u>	<u>2-3x Day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>7-30-09</u>
2 <u>Ambien</u>	<u>10-mg</u>	<u>nightly</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>7-30-09</u>
3 <u>Xanax</u>	<u>1-mg</u>	<u>nightly</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>7-30-09</u>
4 <u>Dilaudid</u>	<u>2mg</u>	<u>q 8 hrs PRN</u>	<input type="checkbox"/>	<input type="checkbox"/>	<u>1mg 7-30-09</u>
5			<input type="checkbox"/>	<input type="checkbox"/>	
6			<input type="checkbox"/>	<input type="checkbox"/>	
7			<input type="checkbox"/>	<input type="checkbox"/>	
8			<input type="checkbox"/>	<input type="checkbox"/>	
9			<input type="checkbox"/>	<input type="checkbox"/>	
10			<input type="checkbox"/>	<input type="checkbox"/>	
11			<input type="checkbox"/>	<input type="checkbox"/>	
12			<input type="checkbox"/>	<input type="checkbox"/>	
13			<input type="checkbox"/>	<input type="checkbox"/>	
14			<input type="checkbox"/>	<input type="checkbox"/>	
15			<input type="checkbox"/>	<input type="checkbox"/>	

For Surgery Patients - Last Beta-Blocker taken at:

Date:

Time:

N/A

MD Notified: \_\_\_\_\_

Nurse Signature &amp; Read Back by: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

MD Signature: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

X to PHARMACY. Place this page in the PHYSICIAN'S ORDERS section.

Set 1 of 2

Top Page: Chart (Phys Orders) Third Page: Chart  
Second Page: Patient / Facility

Rev. 5/09

32257 3038972

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028831600

QSD MR#00889930 008-03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM D 2/3/2008

DATE

9/9/2009

BC 00520

## Francis Hospital



660-18

LOCATION BRACELET: <input checked="" type="radio"/> N		ALLERGY BRACELET: <input checked="" type="radio"/> N/A		INITIALS	
ALLERGIES: Morphine Codeine Zofran				Sending Dept. Nurse	Receiving Dept. Nurse
PROCEDURE: Gastric Pacer/Generator Battery Exchange					
PROCEDURE CONSENT SIGNED and WITNESSED <input checked="" type="checkbox"/> Yes					
NPO AFTER: 7-30-09					
H & P ON CHART (older than 30 days from admit date need new H&P; within 30 days need update)					
MAR PLACED IN CHART					
OPERATIVE AREA PREPPED AND/OR CLIPPED					
VITAL SIGNS: BP: 100/60 P: 80 R: 16 T: 98.8					
HT: 5'3" WT: 113.7 BMI: 19.6					
ISOLATION STATUS: NO YES TYPE:					
CIRCLE APPLICABLE ITEMS					
GLASSES / CONTACTS / DENTURES / PARTIALS REMOVED					
JEWELRY / PINS / UNDERGARMENTS REMOVED					
OTHER PROSTHESIS REMOVED:					
LAB WORK DATE/TIME DRAWN:					
CBC 7/20/09		DIFF		CMP 7/20/09	
BUN		CR		UA	
PT		APTT		PFT	
PREGNANCY TEST: <input checked="" type="checkbox"/> No		N/A 7/31/09		FIBRINOGEN	
OTHER LAB:					
TYPE / CROSSMATCHED R#				BLOOD BRACELET / PERMIT	
CXR		OTHER RADIOLOGY		EKG 7/18/09	
ACCUCHECK RESULTS:				TIME:	
ABNORMAL RESULTS REPORTED TO Surgeon or Anesthesia				DATE/TIME: 7-31-09	
OTHER PERTINENT INFO:				1030	
BETA-BLOCKER LAST DOSE TAKEN:				DATE/TIME: <input type="checkbox"/> NA	
*If on home beta-blocker all surgery patients should receive home dosage within 24hrs prior to surgery. If dose hasn't been taken call Anesthesia for one time pre-op order.					
*All cardiovascular surgery patients should receive beta-blocker within 24hrs pre-op. Or documentation of contraindication.					
SCD / TED's: Tension Exposed CNA 945				TE	
VOIDED / CATHETERIZED TIME:					
INT/IV SITE:		GAUGE:		IV: RATE: LTC:	
INT/IV SITE:		GAUGE:		IV: RATE: LTC:	
PRE-MED:		ROUTE:		TIME:	
PRE-MED:		ROUTE:		TIME:	
PRE-MED:		ROUTE:		TIME:	
TIME/NAME OF PROCEDURAL STAFF NOTIFIED PATIENT READY: Tom - 10:10					
TIME PATIENT LEFT UNIT: 10:40		FAMILY LOCATION: 30		PHONE #: 765-2301	
NURSE SIGNATURE: Julie Gorman					
NURSE SIGNATURE: Dianne Roberts					

BOLD FEA VERIFICATION REQUIRED BY OR

PRE-PROCEDURE CHECK LIST

Page 1 of 2

R06 / 09



028831600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

33737 3306027

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DATE

9/9/2009

BC 00521



**Saint Francis Hospital**  
Memphis



BMI	18	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height (inches)	Body Weight (pounds)																
58	91	98	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	118	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	185	192	198	204	210	216
67	121	127	134	140	146	153	159	165	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	129	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	190	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	226	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	188	197	205	213	221	230	238	246	254	263	271	279	287

BMI	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																		
58	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	176	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	180	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	196	202	207	213	218	224	229	235	240	245	251	256	262	267	273	278	284	289	295
63	203	208	214	220	225	231	237	242	248	254	259	265	270	276	282	287	293	299	304
64	208	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	223	229	235	241	247	253	259	265	271	277	283	289	295	301	307	313	319	325	331
67	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	336	344
68	236	243	249	256	262	268	275	281	288	295	302	308	315	322	328	335	341	348	354
69	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	280	287	295	303	311	318	326	334	342	350	358	366	373	381	389	396	404	412	420
75	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

PRE-PROCEDURE CHECK LIST

Page 2 of 2

R11/07



028931600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

250275008025

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DATE

9/9/2009

BC 00522



Saint Francis Hospital

page 14 of 15  
7/3/19

\*665-03\*

## PACU RECORD SECOND SHEET

TIME	B/P	P	R	TEMP	SaO <sub>2</sub>	Pain 0-10	ACT	RESP	Ct	NEURO	O <sub>2</sub> Sat	MEDS 4-LAB-TX	OBSERVATIONS
134												Benadryl 2.5mg IV for 40 itching face Caled swell	ch having face & redness or rash
134	100/68	66	10	97.1	100	2	2	2	2	2			PRs equal and clear ET g-2 demonstrated to (P) lower abd and intact abdomen soft and flexible pain, nausea and itching Relieved 2 Meds Conclution stable to SDS

(Patient Information in Area Below)

FORM NO. 665-03, REV. 1/06  
BMS # 127333

028831600

OSD MR#00989930 008/03/23/1956  
RILEY, TERRI P 43 F  
CHESON, WILLIAM 0701/2009  
SAINT FRANCIS HOSPITAL, INDIANAPOLIS

PRINTED BY: MClemmons

DATE

9/9/2009

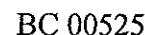
00000000000000000000

BC 00523



'665-01'

(Patient Information in Area Below)



## Aldrete Scoring System

		Score
A. Activity:	An evaluation of the muscular activity of the body assessed by observation. Indicates ability to move all four extremities voluntarily or on command. Can lift head and has controlled movement. Exceptions: patients with a prolonged block such as Marcaine may not move an affected extremity for as long as 18 hours; patients who were immobile preoperatively for as long as 18 hours; patients who were immobile preoperatively for as long as 18 hours; patients who were immobile preoperatively for as long as 18 hours.	2 1 0
B. Respiration:	An evaluation of respiratory efficiency. No complicated apparatus or sophisticated physical tests are utilized. 1. Can take a deep breath and cough well, has normal respiratory rate and depth. 2. Labored or limited respirations. Breathes by self but has shallow, slow respirations; may have an airway device. 3. Apneic, condition necessitates ventilator or assisted respiration.	2 1 0
C. Circulation:	A measurement of cardiovascular hemostasis and a comparison with a previous blood pressures excluding intra-operative. 1. Stable B/P and pulse. B/P 20mm/Hg of pre-anesthetic level (minimum 90 mm/Hg systolic). Exception, patient may be released by anesthesia provider after drug therapy. 2. B/P within 20-50 mm/Hg of pre-anesthetic level. 3. Has abnormally high or low blood pressure, B/P 50 mm/Hg pre-anesthetic level. Note: great differences in diastolic pressure should be noted.	2 1 0
D. Neurologic Status:	Ability of patient to answer simple questions and follow verbal commands - verbal stimuli only (unless patient is deaf). 1. Awake and alert; oriented to time, place, and person. 2. Responds to verbal stimuli but drifts off to sleep easily. 3. Not responding or responding only to painful stimuli.	2 1 0
E. Oxygen Saturation:	1. Able to maintain O2 Saturation > 92% on room air. 2. Needs O2 inhalation to maintain O2 saturation > 90%. 3. O2 saturation < 90% even with O2 supplement.	2 1 0

To be released from PACU, patient must have a score of nine or ten.  
If this score cannot be attained, justification must be stated below.

PHYSICIAN

## POST ANESTHESIA CARE UNIT NURSING CARE PLAN

Nursing Diagnosis	Expected Outcomes	Goals Met	Nursing Diagnosis	Expected Outcomes	Goals Met
A. Potential for impaired gas exchange.	Patient airway will be maintained without respiratory distress and SpO2 > 90%	Yes No N/A Comments	E. Potential for fluid volume imbalance related to NPO status and surgical procedure.	Patient will maintain adequate fluid & electrolyte balance while in PACU.	Yes No N/A Comments
B. Potential for altered cardiac output.	Patient will remain hemodynamically stable (vital signs and urine output).	Yes No N/A Comments	F. Potential for anxiety related to surgical procedure for communication barrier.	Patient will demonstrate controlled level of anxiety.	Yes No N/A Comments
C. Potential for altered peripheral tissue perfusion related to surgical procedure and/or dressing/cast.	Adequate circulatory checks.	Yes No N/A Comments	G. Potential for alteration in comfort.	Patient will demonstrate reasonable level of comfort.	Yes No N/A Comments
D. Potential for altered thought processes related to meds, or surgical procedure.	Patient will achieve optimal level of consciousness.	Yes No N/A Comments	H. Potential for altered body temperature.	Adequate body temperature maintained.	Yes No N/A Comments

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DATE

9/9/2009

BC 00526



**Saint Francis Hospital**  
Memphis



1000-608

Patient Criteria	NPO	RL Meds	No Labs	HCG	EKG	K+	Glu	CBC/ BMP	PT/ INR	CXR	LFT	TSH 13 14
1. At least 8 hrs. prior to O.R.	*											
2. Takes reflux, ulcer, cardiac, antihypertensives, respiratory, and/or seizure meds, in A.M. of O.R. with sip of water.		*										
3. Healthy pediatric.			*									
4. Minor procedures under local anesthesia with IV sedation unless patient meets criteria in 6, 8, 10, 12, 15 or 16.			*									
5. Females of childbearing capability (day of surgery).												
6. Cardiac risk factors: CHF, CAD, PVD, HTN, MI, diabetes, ICD, pacemaker, 50 yrs. or older, hyperlipidemia, family Hx of MI under 50 y/o. A copy of an EKG done within 3 months of surgery is acceptable on stable patients with these risk factors.												
7. Chemo or radiation therapy within 1 yr.					*			*		*		
8. Smokes 15-pack year.					*					*		
9. Diuretics or dialysis (day of surgery).						*						
10. Accouchment on diabetics and patients undergoing heart surgery (day of surgery).							*					
11. On Antihyperthyroidism meds.												*
12. On Coumadin or Hx of bleeding disorders (day of surgery).									*			
13. Hx. of alcoholism, liver disease, morbid obesity, drug abuse, or on entilipid meds.											*	
14. General, regional, IV sedation, retinal bulbar block or taking weight reduction meds.								*				
15. Dyspnea at rest or acute respiratory distress.					*					*		
16. Chest discomfort since last cardiac workup, get previous EKG for comparison.												

*Done 7/31/09 MK*

Lab work must be within 30 days of procedure

Call Anesthesia at 3485 or 2100 regarding abnormal test results.

Nurse Signature: *[Signature]*

Date: *7/31/09*

Time: *920*

**OUTPATIENT SURGICAL  
PREOPERATIVE PROTOCOL**  
Page 1 of 1



OP# MR#0989930 DOB:03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
SAINT FRANCIS HOSPITAL MEMPHIS

028831600

MR# DOE

R12/07

00257 6009827

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DATE

9/9/2009

BC 00527



**Saint Francis  
Hospital - Memphis**

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\*660-12A\*

## SURGERY RECORD

**Preoperative Phase** DATE 7-31-09

Relevant Medical HX \_\_\_\_\_

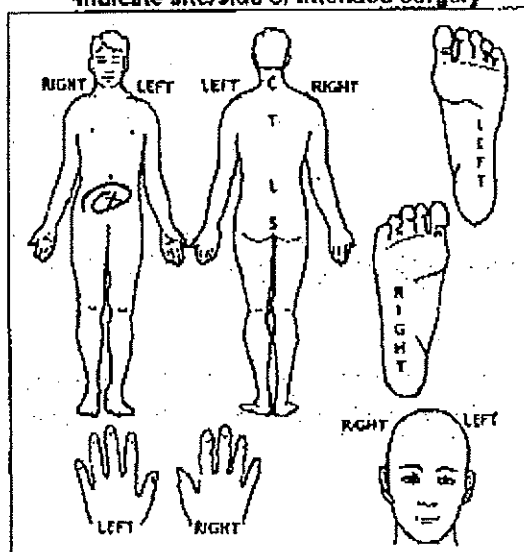
☐ Emergency

☐ Diabetes ☐ HTN ☐ CAD ☐ ESRF

Allergies Morphine Codeine Zephor ☐ No Allergies

☒ NPO pm ☐ NA

Indicate site/side of intended surgery



### Nursing Data Measures

**1. Measures - Risk of injury related to transport:**  
Supportive systems in holding area

☐ NA ☐ Monitor ☐ O2 \_\_\_\_\_

☐ Hearing Aid ☐ Glasses

☐ Pacemaker ☐ Foley ☐ Other \_\_\_\_\_

☒ TCO/SCD activated prior to procedure

Pt identification confirmed by

☒ Patient/Name ☐ Blood available

☒ Armband/MR# ☐ Blood band # \_\_\_\_\_

☐ Caregiver verifies

Transport to operating room via

☒ Stretcher (rails up) ☐ Crib - Rails up

☐ Bed - rails up ☐ Carried

**2. Physical assessment:**

Level of consciousness

☒ Alert/Oriented ☐ Disoriented

☐ Unresponsive ☐ Sedated ☐ Neuro check

Sensory impairment

☒ No limitations ☐ Hearing

☐ Language barrier ☐ Sight

☐ Use interpreter

**Musculoskeletal status**

☒ No Limitations ☐ Paralysis ☐ Traction

☐ Weakness ☐ Limited mobility \_\_\_\_\_

**Skin appearance/integrity**

☒ Warm/Dry ☐ Intact ☐ Cool ☐ Skin color 1/C

☐ Hematoma/bruise/redness - See nurses note

☒ Jewelry removed

☐ Belongings returned to \_\_\_\_\_

**Cardiopulmonary status**

☒ Breathing normal ☐ Abnormal chart EKG noted

☐ Peripheral edema present ☐ Cough ☐ Dyspnea

**Dental status**

☒ Good ☐ Poor ☐ Loose Teeth

☐ Dentures removed

**3. Measures - Risk for pain:**

Pain assessment Scale of 0 to 10 0

Location \_\_\_\_\_

☒ Instructed on use of pain scale ☐ Unable to assess

**4. Measures - Risk for anxiety related to knowledge deficit and stress of surgery:**

Psychological/Spiritual Assessment

☒ Calm ☐ Anxious ☐ Restless ☐ Other \_\_\_\_\_

☒ Provided instruction based on age/population

☒ Needs identified ☐ Stand by/touch patient

☒ Communicated patient concerns to appropriate members of health care team

☒ Explained sequence of events and routine

☒ Evaluated response to instruction

**5. Outcomes:**

☐ Demonstrates adequate pain management

☒ Indicates decreased level of anxiety

☒ Questions answered

### Intraoperative Phase

**"TIME OUT" VERIFICATION:** Time 1147

☒ Correct patient ☒ Antibiotics given ☐ NA

☒ Correct procedure ANCEGMT

☒ Side/site verified

☒ Equipment/Implants/x-rays available

☐ Prep dry, no pooling under patient

☒ All members of team actively participate

Signature Joanne Roberts

Print \_\_\_\_\_

Name Joanne Roberts

▼ Patient Information ▼



028831600

OSD MR#0889930 OBR:03/23/1966

RILEY, TERRI P 43 F

DIBSON, WILLIAM 07/31/2009

SANT FRANCIS HOSPITAL MEMPHIS

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DATE 9/9/2009

BC 00528

**SURGERY RECORD**

660-128

DATE 7-31-09**Operating room progress notes/times**

OR ROOM # <u>21</u>	Pt in room <u>1125</u>	Anesthesia/Intubation <u>1136</u>
Procedure Start <u>1140</u>	Procedure End <u>1248</u>	Patient Out <u>1224</u>

**Skin Prep**

By: Dr. Gibson  
☐ Providone iodine ☒ Chlorhexidine ☐ Duraprep  
☐ Surgical Clippers ☒ Area prepped by hand

**Secondary procedure**

OR ROOM #	Pt in room	Anesthesia/Intubation
Procedure Start	Procedure End	Patient Out

**Perfusion pump time**On            Off           **Monitoring**

☐ RN monitored ☐ EKG ☐ Oximeter ☐ NIBP  
☐ Local with IV sedation ☐ Local/no sedation  
☒ Anesthesia monitored - see anesthesia record

**6. Measures - Risk of infection:****Wound classification**

☒ Clean ☐ Clean/contaminated  
☐ Contaminated ☐ Infected/dirty

**PREOP****DIAGNOSIS****POSTOP****DIAGNOSIS****PROCEDURE****7. Measures - Risk for impaired skin integrity.****Position**

Positioned by staff  
☒ Supine ☐ Prone ☐ Lithotomy ☐ Jackknife ☐ Sitting  
☐ Right lateral side down ☐ Left lateral side down  
☒ OR table ☐ Jackson table ☐ Eye bed/stretchers  
☐ Bariatric table ☐ Fracture table

**Positioning devices**

☒ Safety strap  
☒ Arm boards/padded 2

☐ Arms secured at side/ padded  
☐ Stirrups ☐ Leg holder ☐ Gel roll ☐ Peg board  
☐ Bean bag ☐ Beach Chair ☐ Pillows/wedges

**Padding**

☒ Shear head rest ☒ Elbows ☐ Heels

**8. Measures - Risk of Injury:****Laser**

☐ Laser safety measures implemented

☐ Type            Unit#           

Laser time: On            Off           

Joules            Pulses            Watts           

Duration           

Exposure            Repeat           

**Count**

Sponge ☐ Resolved ☐ Unresolved ☐ NA

Needle ☒ Resolved ☐ Unresolved ☐ NA

Instrument ☐ Resolved ☐ Unresolved ☐ NA

If count unresolved, x-ray taken ☐ Yes ☐ No

If not, explain:

Initial count by RN            Scrub           

Final count by RN            Scrub           

Surgeon notified of counts

**Electrocautery**

☐ Electrocautery unit# 222615

☐ Grounding pad site           

2<sup>nd</sup> Electrocautery unit#           

2<sup>nd</sup> grounding pad site           

**▼ Patient Information ▼**

028831600

OSD MAR00085930 008:0323/1955

RILEY, TERRI P 43 F  
 GIBSON, WILLIAM 07/31/2004  
 SAINT FRANCIS HOSPITAL - MEMPHIS

DATE

9/9/2009

Form 660-128 (Rev 10/07)

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BC 00529



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Hospital - Memphis**

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# **SURGERY RECORD**



\*660-12C\*

DATE 7-31-09

## **8. Measures - Risk of Injury continues:**

Tourniquet unit # \_\_\_\_\_ ☐ Pressure \_\_\_\_\_ ☐  
Applied by \_\_\_\_\_ Site \_\_\_\_\_  
Left ☐ Inflated \_\_\_\_\_ ☐ Deflated \_\_\_\_\_  
Right ☐ Inflated \_\_\_\_\_ ☐ Deflated \_\_\_\_\_  
☐ Post operative pulses checked

## **9. Measures - Risk of hypothermia:**

☐ Temperature monitored  
☐ Warming device Unit # \_\_\_\_\_ setting \_\_\_\_\_  
☐ Warm irrigation or fluids  
☐ Warm blankets Other \_\_\_\_\_

## **POSTOPERATIVE PHASE**

Patient discharged to:

☒ PACU ☐ UICU ☐ Room ☐ Other \_\_\_\_\_  
Via: ☒ Stretcher ☐ Bed ☐ Crib ☐ Carried  
☐ Rails up ☐ Monitor  
Status:  
☒ Awake ☐ Alert ☒ Responds to stimuli  
☒ Extubated  
☐ O2 Lm \_\_\_\_\_ ☐ BNC ☐ Mask ☐ Oral/nasal airway  
☐ Sedated  
☐ Intubated ☐ Ambu bag ☐ LMA ☐ Expired

## **Assessment/Evaluation**

### **10. Outcomes:**

☒ Patient's surgery performed using aseptic technique and in a manner to prevent cross contamination.  
☐ Skin remains intact, non-irritated and free of hematoma ☐ No, see RN note  
☒ Core body temperature remains within expected range ☐ No, see RN note  
☒ Body alignment maintained ☐ No, see RN note  
☒ Pressure areas /skin intact ☐ No, see RN note  
☒ Skin color \_\_\_\_\_ ☐ Dressing dry and clean  
Post operative pain  
Scale 0-10 \_\_\_\_\_ ☒ Unable to assess  
Family/Support person called each hour ☐ NA  
Times \_\_\_\_\_

## **IMPLANT INFORMATION - PAGE 4A**

☐ NO IMPLANT

Reported to Gayle R Circulating Nurse Signature B. J. [Signature]

Nursing notes


## **Medications/fluids/irrigation**

(other than those given by anesthesia)

Medication	Amount	Route	Initials
NLS 1000 x 1			
Kanex 1 g			
Mallory 0.5%			
2.5% 100, 600			

☐ Alternate specialty drug charge sheet utilized

## **Specimens ☐ None**

Cultures:

Pathology: Intestine - Distal  
Heinz bodies  
3 slides

## **Blood products**

RBC	PLATELET	CRYO
FFP	CELL SAVER	

## **Drains/Tubes**

(size/type/site)

Packing \_\_\_\_\_ ☐ Eye patch/shield  
Cast \_\_\_\_\_  
Dressing DermaBond

## **Urine output**

☐ Indwelling urinary catheter present \_\_\_\_\_ ml  
☐ Catheter inserted in OR by \_\_\_\_\_  
Size/Type \_\_\_\_\_  
Color/Quality \_\_\_\_\_  
CABG/Valve: Pre pump \_\_\_\_\_ ml  
Pump \_\_\_\_\_ ml  
Post pump \_\_\_\_\_ ml  
☐ Total intraoperative output \_\_\_\_\_ ml  
☐ Catheter inserted post op/none measured



028831600

OSD MR#00989930 DOB:03/23/1969  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
CARTER, BRADLEY 01/01/2009

DATE 9/9/2009

BC 00530





**Saint Francis Hospital**  
Memphis



735-03

Age 43 Ht 53 Wt 113 M F  
Hgb/Hct 17/37 Chem 4-8 Pregnancy Test ✓ NPO: Yes No  
Last Intake: WNL  
Procedure/Operation: Gastric Bypass

Previous Anesthetics: <u>WNL - noted</u>	Pulmonary <u>WNL</u>	Cardiovascular - EKG <u>WNL</u>
Family Anesthesia Hx:	Smokes: yes <u>no</u> <u>✓</u>	Invasive Monitors Planned:
CNS & Mental <u>WNL</u>	Hepato/Renal <u>WNL</u>	GI, Hiatal Hernia <u>WNL</u> <u>Gastric Pylorus</u>
Eyes (Glaucoma)	Allergies: <u>Morphine, 20 trans</u> <u>Cocaine</u>	Consent Signed <u>✓</u> ASA Class: E <u>2</u> 3 4 5 Planned Anesthesia/Sedation: GEN <u>✓</u> Regional <u>   </u> Spinal <u>   </u> Epidural <u>   </u> Bier Block <u>   </u> Sedation <u>   </u> Other: <u>   </u> Pre-med: <u>   </u>
Current Meds: (include Rx, OTC, Herbal and Dietary Supplements) <u>Yes - noted</u>	Endocrine, Diabetes, Musculoskeletal Disorder: <u>WNL</u>	
ETOH: <u>   </u> Steroids: <u>   </u> Anti-hypertensive: <u>   </u> Blood Transfusions Blood Disorder, Anti-coagulant Therapy: <u>   </u>	Airway Assessment/Teeth: <u>MP I</u>	Post-anesthesia Pain Management:

Comments:

The risks, benefits and alternatives of the anesthesia/sedation have been discussed with the patient and/or family member, including potential teeth damage and possible changes in anesthesia plan that might arise from changes in patient's condition during procedure and they agree to proceed.

CRNA/Anesthesiologist or MD Signature

Date and Time

## Post-operative Anesthetic Note

Complications related to anesthesia/sedation: None General Condition: Satisfactory

CRNA or Attending Anesthesiologist or MD Signature

Date and Time

PRE-ANESTHESIA & SEDATION  
ASSESSMENT AND PLAN  
Page 1 of 2

R&amp;02



028831600

MR# DOB:

OSD MR#00989930 008/03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
CONFIDENTIALITY: REPORT TO WORK

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DATE

9/9/2009

NORTH 5900422

BC 00532



# Saint Francis Hospital

## Memphis

### ASA Risk Class:

- E Emergency
- 1 Healthy patient
- 2 Mild systemic disease, no functional limitations
- 3 Severe systemic disease, definite functional limitations
- 4 Severe systemic disease that is constant threat to life
- 5 Moribund patient not expected to survive 24 hours with or without surgery

PRE-ANESTHESIA & SEDATION  
ASSESSMENT AND PLAN  
Page 2 of 2



MR# DOB:

R&D2

33212 506602

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DATE

9/9/2009

BC 00533

ANESTHESIA		OR		PROCEDURE	
START	END	IN	OUT	START	END
1115	1230	1125	1145	1145	1218

INCISION TIME 1145 \*735-04\*

ANESTHESIA PROVIDERS R. D. Gibson SURGEON Gibson Pre Op Antibiotic Amoxicillin Start 1130

DATE 7/31 DIAGNOSIS Right Pivotal Function Battery PROCEDURE Right Pacemaker Battery Exchange

PATIENT DATA: AGE 43 SEX F HT 53 WT 113 HCT 37 P/S R E TEETH OK

PRE-EXISTING MEDS (DOSE, ROUTE, TIME) Phenytoin 25mg IV PT IDENTIFIED YES ALLERGIES None

TIME	O <sub>2</sub> /LM	NO <sub>2</sub> /AIR LM	VOLATILE	DEB	100	200	300	400	500	600	700	800	900	1000	TOTAL
1115	30	2	2	2	2	2	2	2	2	2	2	2	2	2	
1130	30	2	2	2	2	2	2	2	2	2	2	2	2		
1145	30	2	2	2	2	2	2	2	2	2	2	2	2		
1200	30	2	2	2	2	2	2	2	2	2	2	2	2		
1218	30	2	2	2	2	2	2	2	2	2	2	2	2		

EBL 0 URINE OP 0

MONITORING: SPO<sub>2</sub> 99 ET CO<sub>2</sub> 38 TEMP 36.5 FIO<sub>2</sub> 100 CVP / MAP / SVCO 100 EKG 912

IMMEDIATE REPRODUCTION EVALUATION: PULSE 76 BP 100/60 HR 76 SPO<sub>2</sub> 96 LAB REVIEWED YES LAB NO. EVENTED AS DISCUSSED YES IF NO, SEE BELOW NO PATIENT POS Shp VENTILATOR SETTING Spontaneous Assisted (Control)

Remarks: Right Pacemaker Battery Exchange

VENTILATION: Spontaneous Assisted (Control)

VENTILATOR SETTING

REMARKS:

Patient Label: 028831600

OSD MR#0088830 008-03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
LAST TRANSFERRED TO MEDICAL

CRNA R. D. Gibson ANESTHESIOLOGIST Gibson

I assumed primary responsibility for the anesthesia at the remaining key portions of the procedure and emergency and immediately available for the remainder of the procedure.

PRINTED BY: MCIemmons DATE 9/9/2009



**Saint Francis Hospital**  
Memphis



1000-101

**Advance Care Plan (Advance Directive)  
Acknowledgement**

Does patient have an Advance Directive?

☐ Yes ☒ No ☐ Unknown

Type of Advance Directive ☐ Living Will ☐ Healthcare Power of Attorney ☐ POST Form ☐ Guardian

Where is the Advanced Directive located? ☐ Placed on Chart ☐ Reviewed copy with patient

☐ Requested to bring copy ☐ Unable to obtain

Name of Agent \_\_\_\_\_

Agent phone number \_\_\_\_\_

(of Durable Power of Attorney for Healthcare)

Was the patient/family given information?

☐ Yes ☒ No ☐ NA

Does the patient wish to initiate and Advance Care Plan or Advance Directive or wish additional information?

☐ Yes ☒ No ☐ NA

If yes, Please leave message on Ext. 1832 or 1987 for referral

☐ Yes ☐ No ☒ NA

HOSPITAL REPRESENTATIVE Walter Stevens

DATED 7-27-09

**PASTORAL CARE**

Referral completed: ☐ with Patient ☐ with Spouse ☐ with Spouse and Patient

☐ with other \_\_\_\_\_

☐ Patient declines

Advance Directive follow up: ☐ Placed on chart ☐ Requested to bring copy

☐ Unable to obtain ☐ Reviewed copy with patient

HOSPITAL REPRESENTATIVE \_\_\_\_\_

DATE \_\_\_\_\_

**Advance Directives/Acknowledgement**

Page 1 of 1

Rev 5/08



028831608

OSD MR#00889930 DOB:03/23/1966  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
SAINT FRANCIS HOSPITAL MEMPHIS

MR# DOB:

28867 5008082

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DATE

9/9/2009

BC 00535



**Saint Francis Hospital**  
Memphis



1000-554

**1. Consent to Medical and Surgical Procedures**

I, the patient identified below or the patient's legally authorized representative, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, including testing of blood or other bodily fluid to determine the presence of any communicable disease such as, to the extent allowed by law, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS), x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of my/the patient's physician or surgeon. I further consent to my/the patient's physician or surgeon or his/her designees including other practitioners and hospital personnel, which may include health care professionals in training, performing or administering all tests, services or treatments indicated as previously described.

**2. Consent to Photograph**

I permit the hospital to photograph as a part of the documentation of my/the patient's medical/surgical condition. These photographs will be maintained as part of my/the patient's permanent medical record. I understand and acknowledge that the hospital is permitted to use cameras to monitor all patients.

**3. Nursing Care**

I understand and acknowledge that this hospital will provide nursing care to meet my/the patient's needs in accordance with accepted standards of nursing practices. If I/the patient desire sitter services or the services of a private duty nurse to provide personal care needs, I understand that such retention of such services is my responsibility and I agree to notify the hospital if I intend to arrange for additional or private duty nursing. I also understand and acknowledge that the hospital may use cameras or other devices for patient monitoring.

The undersigned certifies that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative, or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date

7/31/09

Patient/Patient's Authorized Signature

*Terril P. Riley*

If other than patient, indicate relationship

Witness

*Emily Patten*

Witness

Consent For Treatment  
Page 1 of 1

R3/06



028531600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

00027 5000000

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DATE

9/9/2009

BC 00536



**Saint Francis Hospital**  
Memphis



### PATIENT EDUCATION REGARDING SMOKING

#### Quick Facts about Smoking

Smoking-related diseases claim an estimated 430,700 American lives each year. Smoking costs the United States approximately \$97.2 billion each year in health-care costs and lost productivity. It is directly responsible for 87 percent of lung cancer cases and causes most cases of emphysema and chronic bronchitis. One in three smokers die early because of their smoking. They die of heart disease, stroke, cancer and emphysema. What's more, research shows that secondhand smoke, the smoke from other people's cigarettes, can harm the health of nonsmokers. Breathing in another person's smoke can cause many breathing problems in children and cancer and heart disease in adults.

#### Saint Francis Hospital Policy/Rules about Smoking

1. Saint Francis is a nonsmoking institution. Strict guidelines regarding smoking by patients and visitors must be followed. Patients may **NOT** smoke in patient rooms. There are no designated smoking areas anywhere on Saint Francis property, including parking garages.
2. We encourage the use of alternatives instead of smoking. Your physician has the ability to order nicotine replacements for you to assist in quitting smoking while you are hospitalized. We also will provide you with information on the best methods to quit smoking. Your nurse will provide that information to you on request. Failure to comply with our No smoking policy could result in your being discharged against medical advice.
3. If you do not follow the rules regarding smoking, you are subject to have your smoking materials removed from your room, in order to safeguard you, as well as others. The rules have been established for safety reasons as well as health concerns.
4. Smoking in heart patients can result in heart irregularities and sudden death.

I have read the above and have had the opportunity to have any questions I may have asked answered. I understand the rules, and I agree to abide by them while a patient at Saint Francis Hospital. If I do not follow the above policy, I understand that I am responsible for any damage to property, myself, or others and I agree to hold harmless Saint Francis Hospital, its affiliates and their agents and employees from any claims or causes or action which may arise out of my failure to follow the policy.

*Terril P. Riley*  
Patient Signature

Patient Education Regarding Smoking

Page 1 of 1

R06/07



028831600

OSD MR#00989930 DOB:03/23/1966

RILEY, TERRIL P F 43

GIBSON, WILLIAM C 7/31/2009 -

33257 3303-032

PRINTED BY: MCJemmons

DATE

9/9/2009

BC 00537



# Saint Francis Hospital Memphis



## TO THE PATIENT:

If you are having a procedure done by one of the following departments, you can expect to receive two (2) separate bills. One will be from Saint Francis Hospital Memphis to cover the procedure itself and the other from the physician who interprets the results of your test. They will bill you separately. This fulfills the legal requirements established by the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248).

Cardiology:	<b>ALL TESTS</b> East Memphis Electrocardiographers PO Box 241926 Memphis, TN 38124-1926 - Telephone: (901) 384-6554			
Radiology Nuclear Medicine Radiation Therapy:	<b>ALL TESTS</b> Memphis Physicians Radiology Group, PC 2527 Cranberry Hwy. Wareham, MA 02571 - Telephone: (800) 299-9770			
G.I. Lab:	<b>ERCP TESTS</b> Memphis Physicians Radiology Group, PC Department 199, PO Box 1000 Memphis, TN 38148 - Telephone: (901) 761-2160			
Neurophysiology:	<b>ADE EMG and SINGLE FIBER EMG TEST</b> <table border="1"><tr><td>Dr. Alan M. Nadel PO Box 41619 Memphis, TN 38174 Telephone: (901) 726-6916</td><td>Dr. Mohammad Asaal 6005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880</td></tr></table>		Dr. Alan M. Nadel PO Box 41619 Memphis, TN 38174 Telephone: (901) 726-6916	Dr. Mohammad Asaal 6005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880
Dr. Alan M. Nadel PO Box 41619 Memphis, TN 38174 Telephone: (901) 726-6916	Dr. Mohammad Asaal 6005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880			
Pathology:	Tissue pathology, cytology, clinical lab consultations, biopsy procedures, and fees for supervisory services when a sample of your blood, urine, stool or other body fluid is tested in the laboratory to insure clinical reliability, timely reporting, consultation with treating physicians or interpretation of results.  The Pathology Group, PC 8060 Primacy Parkway, Suite 439 Memphis, TN 38119 - Telephone: (901) 881-8087			
Surgery:	The package price includes the following: surgical suite and supplies, recovery room, outpatient preparation and postoperative observation, CBC and urinalysis, anesthesia supplies, routine medications and routine pathology studies.  This special price does not include the following: charges for prosthetic devices, surgeon's fees, anesthesiologist or anesthesiologist fees which may be billed by the hospital, other physician-related fees or take-home drugs. Moreover, Saint Francis Hospital Memphis reserves the right to exclude those rare extraordinary charges from its special ambulatory pricing schedule and will bill the patient accordingly.			
Self Pay:	The price you have been quoted is an estimated amount. There may be additional charges incurred during your testing for which you will receive a statement.			

For information concerning hospital charges, call (901) 765-1850. For questions about Medicare and Medicaid, call (901) 765-1877.

7/31/09  
Date

*Terris P. Riley*  
Patient/Patient's Authorized Signature

*Emily R. Hall*  
Witness

If other than patient, indicate relationship

Witness

Witness

Separate Physician Billing  
Page 1 of 1



026831600

OSD MR#00989930 DOB:03/23/1965

RILEY, TERRIS P F 43

GIBSON, WILLIAM 07/31/2009 -

R3/06

06/23/2009 08:00

PRINTED BY: MClemmons

DATE

9/9/2009

BC 00538



# Saint Francis Hospital Memphis



1000-553

## 5. Release of Information/Medical Records

I hereby consent and authorize the hospital and any practitioner, whether agent or independent contractor of hospital, providing medical goods and services to the patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at the hospital and by any practitioner providing medical goods and services to the patient, including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, mental health/mental retardation and treatment records and/or laboratory test results, medical history, treatment progress, and/or any other such related information to: (1) Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors; (2) Medicare; (3) Medicaid; (4) any other person or entity that may be responsible for paying or processing for payment any portion of my hospital bill; (5) to any person or entity affiliated with or representing the hospital and any practitioner providing medical goods and services to patient for the purpose of administration, billing and quality and risk management; or (6) to any other hospital, nursing home, or other health care institution in which the patient is provided treatment; (7) accrediting, regulating and state agencies. This consent and authorization applies to financial and/or medical records created in the course of and relating to this, or subsequent related hospitalization. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred for treatment at the hospital and by any practitioner providing medical goods and services to patient. I also authorize the release of medical information to organ transplantation services should the patient be identified as a potential organ donor. The consent to release medical information is subject to revocation in writing any time, except to the extent that action has been taken. I further understand that unless I otherwise instruct the hospital, in writing, the hospital may release directory information pertaining to me without my consent.

## Authorization to Appeal

I hereby authorize the hospital to appeal on my behalf my claim(s) with, if applicable, and/or any payer which denies and/or delays payment of my claim(s). I further authorize that the payor, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the hospital and/or its attorneys. Unless prohibited by applicable law or regulation, this authorization is irrevocable upon execution by me hereinbelow and any appeal brought by the hospital shall be as if it was brought by me personally.

## 6. Personal Valuables

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars (\$500.00) unless a written report for a greater amount has been obtained from the hospital by the patient.

## 7. I have Received the Additional Facility Specific Addendum (Check appropriate boxes)

☒ Patient Rights and Responsibilities;

☐ Important Message from Medicare;

☐ Important Message from Champus;

☐ Authorization to Disclose

☐ Other Specific Items as listed:

☒ Information regarding Advance Directives

☐ Not Applicable

Patient has executed Advance Directives:

☐ Yes ☒ No

Did you bring a copy?

☐ Yes ☐ No

If no, Whom to contact to receive a copy?

## 8. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 1) and Assignment of Benefits to Hospital and Hospital-Based Physicians (Paragraph 2) set forth above.

7/31/09  
Date

Financially Responsible Party

Witness

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date

Patient/Patient/Guardian/Conservator/Responsible Party - The above conditions of services have been explained to me and I understand.

If other than patient, indicate relationship

Witness

Witness

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT

Conditions of Service  
Page 2

R3/06



026834600

OSD MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00539



# Saint Francis Hospital Memphis



1000-553

## 1. Financial Responsibility

In consideration of services rendered or to be rendered to patient, the undersigned, whether he/she is the patient, patient's relative, patient's legal guardian, representative, agent, other individual or entity, hereby obligates himself/herself individually, to the hospital, physicians, surgeons, emergency department physicians, radiologists, pathologists, anesthesiologists, and consultants involved in the patient's care and agrees to pay for any and all charges and expenses incurred or to be incurred. It is agreed and understood that regardless of any and all assigned benefits/monies; I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the hospital, and the appropriate physicians, surgeons, emergency department physicians, radiologists, pathologists, anesthesiologists and consultants involved in patient's care and agree to pay for any and all charges and expenses incurred or to be incurred. It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all patient charges, reasonable attorney's fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. All delinquent accounts may be charged interest at the maximum rate allowed by law.

## 2. Assignment Of Benefits To Hospital And Hospital-Based Physician

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to the hospital, and hospital-based physicians (e.g., radiologists, pathologists, anesthesiologists, emergency department physicians) all rights, title and interest in all benefits/monies payable for services/supplies rendered, including but not limited to group medical/indemnity/self-insured/ERISA benefits/coverage, PIP, UIM/UIM, auto/homeowner insurance, and in all causes of action against any party or entity that may be responsible for payment of benefits/monies regardless of whether or not I ultimately settle my claim with a non-admission of liability provision. I fully understand that in the event the hospital and/or hospital-based physicians files a claim on my behalf that the same does not impose any contractual obligation or otherwise upon the hospital and/or hospital-based physicians, and that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits, I remain fully responsible for instituting, and am expressly authorized by the hospital and hospital-based physicians to institute, suit within the applicable statutes of limitations. I authorize the hospital and/or hospital-based physicians to appeal any denial under my appeal rights provision. It is hereby agreed and understood that any condition precedent subsequent or otherwise, including, but not limited to, precertification, preauthorization, or second opinions shall remain the sole responsibility of patient and/or the patient's family, legal guardian, representative or agent. I further understand that failure to pre-certify could result in reduced payments from patient's insurance company, leaving the undersigned financially responsible for the non-reimbursed portion of patient's bill. It is further agreed and understood that the obtaining of verification of benefits and/or precertification does not in any form or fashion relieve the patient, or the patient's family, other individual or entity signing on behalf of patient, of any liability for the financial responsibility for goods and services provided or to be provided to patient by the hospital and/or hospital-based physicians and any other associated physician. I fully understand and agree that hospital and/or hospital-based physicians shall be entitled to full payment where a third-party accident is involved notwithstanding any benefits payable by a managed care payer on my behalf as third-party bears primary responsibility.

## 3. Assignment of Cause of Action and Benefits

I, for good and valuable consideration receipt of which is hereby acknowledged, irrevocably assign and transfer, to the hospital, any and all claims, demands, suits, remedies, guarantees, liens and/or causes of action, at law or in equity, either in contract or in tort, statutory or otherwise, to the extent permitted by law, as well as any other claim, in whole or in part, which I may now have or may hereafter hold or possess, known or unknown, on account of, growing out of, relating to or concerning, whether directly or indirectly, proximately or remotely, any acts, omissions, events, transactions or occurrences that have occurred or failed to occur which resulted in my injuries for which the hospital has provided and/or will provide medical goods and services to me. This Assignment of Cause of Action and Benefits shall be effective against any and all parties or entities that may bear or appear to bear liability for my injuries, including but not limited to, my employer, its direct and indirect subsidiaries, all of its officers, directors, agents, servants, successors, assigns and employees. I further assign and transfer to the hospital, any and all rights (including appeal rights), title and interest in any and all benefits, monies or other form of compensation paid or to be paid on my behalf as a result of this injury/illness. I fully understand that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits, I remain solely responsible for instituting, and am expressly authorized by the hospital to institute, suit within the applicable statutes of limitations, and that the hospital is not in any form or fashion responsible for instituting suit on my behalf. I understand and agree that this Assignment does not relieve me of my liability or responsibility for any and all charges incurred as a result of medical goods and services provided to me by the hospital.

## 4. Medicare Patient's Assignment of Benefits and Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance.

## 5. Legal Relationship Between Hospital and Physician

All physicians and surgeons furnishing services to the patient, including the Emergency Department physicians, radiologists, pathologists, anesthesiologists and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

Conditions of Service  
Page 1 of 2

R3/06



028531600

OSD MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

09257 3003437

PRINTED BY: MClammons

DATE

9/9/2009

BC 00540



**Saint Francis Hospital**  
Memphis



1000-555

### NOTICE REGARDING FACILITY DIRECTORY

Dear Patient/Patient's Personal Representative:

We maintain a list of information on our patients. This list is referred to in our *Notice of Privacy Practices* (NPP) as the Directory of Individuals. This Directory includes a patient's name, location in the hospital, general condition and religious affiliation. However, a patient's religious affiliation will only be disclosed to clergy.

We may use this information in the following ways:

**The Patient Information Desk** - uses the Directory to forward calls from friends or loved ones to a patient. They may use it to accept flowers or balloons sent to the patient. They use it to direct visitors to a patient's room.

**The Security Department** - uses the Directory to know at all times who is in the hospital, so they can prepare for any emergency and account for all patients.

**Telephone Operators** - use the Directory to forward calls to patients.

**Clergy** - use the Directory to make visits to patients and their families.

Every patient has a right to ask that their name, location in the hospital, general condition and/or religious affiliation be omitted from the Directory.

If you wish to be removed from this list, complete the Directory Opt Out form below.

### DIRECTORY OPT OUT FORM

Every patient has a right to ask that their name, location in the hospital, general condition or religious affiliation be omitted from the Directory. If you wish to remove all or part of your information from the Directory, please check those items that you do not want included:

- ☐ **Name** - If you select this box, we will not be able to share any information about you with anyone who asks for you by name, including family or friends. We will have to state that we cannot confirm or deny that you are a patient. *If you select this box, no additional selections are required.*
- ☐ **Location** - If you select this box, you cannot receive flowers, mail, phone messages, etc.
- ☐ **General Health Condition** - If you select this box, we cannot share information about your general condition with anyone who asks for you by name, including family or friends.
- ☐ **Religious Affiliation** - If you select this box, we cannot share information about you with clergy.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices (NPP), and is the patient, or the patient's personal representative.

7-31-09

Date

Time

*Terri P. Riley*

Signature of Patient or Patient's Personal Representative

Relationship of Personal Representative to Patient (if applicable)

Print Name of Patient or Patient's Personal Representative

Directory Opt Out Form

Page 1 of 1

R3/06



028831600

OPM MR#00989930 DOB:03/23/1988

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

00557 550000X

PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00541



**Saint Francis Hospital**  
Memphis



1000-556

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Terri P. Riley  
Name of Patient

Terri P. Riley  
Signature of Patient

7/31/09  
Date Signed

\_\_\_\_\_  
Name of Patient's Personal Representative

\_\_\_\_\_  
Signature of Patient's Personal Representative

\_\_\_\_\_  
Date Signed

**FOR INTERNAL USE ONLY**

Emily Full  
Name of Employee

Emily Full  
Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.  
☐ Patient refused to sign.  
☐ Other \_\_\_\_\_

Version 2 (As noted on NPP)

12/08/03 (Date: As noted on NPP)

**Notice of Privacy Practices  
(NPP) Acknowledgement**  
Page 1 of 1



028831600

QPM MR#00989930 DOB:03/23/1966

**RILEY, TERRI P F 43**

GIBSON, WILLIAM 07/31/2009

R3/06

08257 5003682

PRINTED BY: MClennons

DATE 9/9/2009

BC 00542



# Saint Francis Hospital Memphis



1000-554

## 1. Consent to Medical and Surgical Procedures

I, the patient identified below or the patient's legally authorized representative, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, including testing of blood or other bodily fluid to determine the presence of any communicable disease such as, to the extent allowed by law, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS), x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of my/the patient's physician or surgeon. I further consent to my/the patient's physician or surgeon or his/her designees including other practitioners and hospital personnel, which may include health care professionals in training, performing or administering all tests, services or treatments indicated as previously described.

## 2. Consent to Photograph

I permit the hospital to photograph as a part of the documentation of my/the patient's medical/surgical condition. These photographs will be maintained as part of my/the patient's permanent medical record. I understand and acknowledge that the hospital is permitted to use cameras to monitor all patients.

## 3. Nursing Care

I understand and acknowledge that this hospital will provide nursing care to meet my/the patient's needs in accordance with accepted standards of nursing practices. If I/the patient desire sitter services or the services of a private duty nurse to provide personal care needs, I understand that such retention of such services is my responsibility and I agree to notify the hospital if I intend to arrange for additional or private duty nursing. I also understand and acknowledge that the hospital may use cameras or other devices for patient monitoring.

The undersigned certifies that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative, or I am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

7-31-09  
Date

*Terrri P. Riley*  
Patient/Patient's Authorized Signature

If other than patient, indicate relationship

Witness

*Emily Puck*

Witness

Consent For Treatment  
Page 1 of 1

R3/06



028831600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

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PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00543



# Saint Francis Hospital Memphis



1000-553

## 6. Release of Information/Medical Records

I hereby consent and authorize the hospital and any practitioner, whether agent or independent contractor of hospital, providing medical goods and services to the patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at the hospital by any practitioner providing medical goods and services to the patient, including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, mental health/mental retardation and treatment records and/or laboratory tests results, medical history, treatment progress, and/or any other such related information to: (1) Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors; (2) Medicare; (3) Medicaid; (4) any other person or entity that may be responsible for paying or processing for payment any portion of my hospital bill; (5) to any person or entity affiliated with or representing the hospital and any practitioner providing medical goods and services to patient for the purpose of administration, billing and quality and risk management; or (6) to any other hospital, nursing home, or other health care institution in which the patient is provided treatment; (7) accrediting, regulating and state agencies. This consent and authorization applies to financial and/or medical records created in the course of and relating to this, or subsequent related, hospitalization. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred for treatment at the hospital and by any practitioner providing medical goods and services to patient. I also authorize the release of medical information to organ transplantation services should the patient be identified as a potential organ donor. The consent to release medical information is subject to revocation in writing any time, except to the extent that action has been taken. I further understand that unless I otherwise instruct the hospital, in writing, the hospital may release directory information pertaining to me without my consent.

## Authorization to Appeal

I hereby authorize the hospital to appeal on my behalf my claim(s) with, if applicable, and/or any payer which denies and/or delays payment of my claim(s). I further authorize that the payors, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the hospital and/or its attorneys. Unless prohibited by applicable law or regulation, this authorization is irrevocable upon execution by me hereinbelow and any appeal brought by the hospital shall be as if it was brought by me personally.

## 8. Personal Valuables

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars (\$500.00) unless a written report for a greater amount has been obtained from the hospital by the patient.

## 9. I have Received the Additional Facility Specific Addendum (Check appropriate boxes)

☒ Patient Rights and Responsibilities;

☐ Important Message from Medicare;

☐ Important Message from Champus;

☐ Authorization to Disclose

☐ Other Specific Items as Listed:

☒ Information regarding Advance Directives

☐ Not Applicable

Patient has executed Advance Directives:

☐ Yes ☒ No

Did you bring a copy?

☐ Yes ☐ No

If no, whom to contact to receive a copy?

## 10. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 1) and Assignment of Benefits to Hospital and Hospital Based Physicians (Paragraph 2) set forth above.

7/3/09  
Date

*Terri P. Riley*  
Financially Responsible Party

Witness

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date

Patient/Parent/Guardian/Conservator/Responsible Party - The above conditions of services have been explained to me and I understand.

*Emily Riddle*  
Witness

If other than patient, indicate relationship

Witness

Witness

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT

Conditions of Service  
Page 2



028831800

OSD MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

R3706

PRINTED BY: Mclemmons

DATE

9/9/2009

037257 3009412

BC 00544



# Saint Francis Hospital Memphis



1000-553

## 1. Financial Responsibility

In consideration of services rendered or to be rendered to patient, the undersigned, whether he/she is the patient, patient's relative, patient's legal guardian, representative, agent, other individual or entity, hereby obligates himself/herself individually, to the hospital, physicians, surgeons, emergency department physicians, radiologists, pathologists, anesthesiologists, and consultants involved in the patient's care and agrees to pay for any and all charges and expenses incurred or to be incurred. It is agreed and understood that regardless of any and all assigned benefits/monies; I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the hospital, and the appropriate physicians, surgeons, emergency department physicians, radiologists, pathologists, anesthesiologists and consultants involved in patient's care and agree to pay for any and all charges and expenses incurred or to be incurred. It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all patient charges, reasonable attorney's fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. All delinquent accounts may be charged interest at the maximum rate allowed by law.

## 2. Assignment Of Benefits To Hospital And Hospital-Based Physician

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to the hospital, and hospital-based physicians (e.g., radiologists, pathologists, anesthesiologists, emergency department physicians) all rights, title and interest in all benefits/monies payable for services/supplies rendered, including but not limited to group medical/indemnity/self-insured/ERISA benefits/coverage, PIP, UIM/UIM, auto/homeowner insurance, and in all causes of action against any party or entity that may be responsible for payment of benefits/monies regardless of whether or not I ultimately settle my claim with a non-admission of liability provision. I fully understand that in the event the hospital and/or hospital-based physicians files a claim on my behalf that the same does not impose any contractual obligation or otherwise upon the hospital and/or hospital-based physicians, and that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits, I remain fully responsible for instituting, and am expressly authorized by the hospital and hospital-based physicians to institute, suit within the applicable statutes of limitations. I authorize the hospital and/or hospital-based physicians to appeal any denial under my appeal rights provision. It is hereby agreed and understood that any condition precedent, subsequent or otherwise, including, but not limited to, precertification, preauthorization, or second opinions shall remain the sole responsibility of patient and/or the patient's family, legal guardian, representative or agent. I further understand that failure to pre-certify could result in reduced payments from patient's insurance company, leaving the undersigned financially responsible for the non-reimbursed portion of patient's bill. It is further agreed and understood that the obtaining of verification of benefits and/or precertification does not in any form or fashion relieve the patient or the patient's family, other individual or entity signing on behalf of patient, of any liability for the financial responsibility for goods and services provided or to be provided to patient by the hospital and/or hospital-based physicians and any other associated physician. I fully understand and agree that hospital and/or hospital-based physicians shall be entitled to full payment where a third-party accident is involved notwithstanding any benefits payable by a managed care payor on my behalf as third-party bears primary responsibility.

## 3. Assignment of Cause of Action and Benefits

I, for good and valuable consideration receipt of which is hereby acknowledged, irrevocably assign and transfer, to the hospital, any and all claims, demands, suits, remedies, guarantees, liens and/or causes of action, at law or in equity, either in contract or in tort, statutory or otherwise, to the extent permitted by law, as well as any other claim, in whole or in part, which I may now have or may hereafter hold or possess, known or unknown, on account of, growing out of, relating to or concerning, whether directly or indirectly, proximately or remotely, any acts, omissions, events, transactions or occurrences that have occurred or failed to occur, which resulted in my injuries for which the hospital has provided and/or will provide medical goods and services to me. This Assignment of Cause of Action and Benefits shall be effective against any and all parties or entities that may bear or appear to bear liability for my injuries, including but not limited to, my employer, its direct and indirect subsidiaries, all of its officers, directors, agents, servants, successors, assigns and employees. I further assign and transfer to the hospital, any and all rights (including appeal rights), title and interest in any and all benefits, monies or other form of compensation paid or to be paid on my behalf as a result of this injury/illness. I fully understand that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits, I remain solely responsible for instituting, and am expressly authorized by the hospital to institute, suit within the applicable statutes of limitations, and that the hospital is not in any form or fashion responsible for instituting suit on my behalf. I understand and agree that this Assignment does not relieve me of my liability or responsibility for any and all charges incurred as a result of medical goods and services provided to me by the hospital.

## 4. Medicare Patient's Assignment of Benefits and Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance.

## 5. Legal Relationship Between Hospital and Physician

All physicians and surgeons furnishing services to the patient, including the Emergency Department physicians, radiologists, pathologists, anesthesiologists and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

Conditions of Service  
Page 1 of 2



028831600

OSD MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

R3/06

2222 20000000

PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00545



# Saint Francis Hospital Memphis



601-09

Dated: 7-31 2009 Time: 10:15 o'clock X A.M.    P.M.

## THIS PARAGRAPH AUTHORIZES THE SURGEON TO OPERATE:

- I consent and authorize Dr. Gibson and any associates or assistants or consultants of his / her choice to perform the following medical / surgical operation, treatment or procedure:  
Gastric Pacemaker Battery Exchange
- I hereby consent to the performance of the operations, treatments or procedures, and the possibility that I may receive an implantable device, in addition to, or different from, those now contemplated which the above-named physician or assistants may consider necessary or advisable in the course of the operation, treatment and / or procedure, as well as services involving pathology, radiology, transfusions, injections and tests.
- The nature and purpose of the operation, treatment and / or procedure, the possible alternative methods, the risks involved and the possibility of complications have been fully explained to me, including the option and possible complication of an implantable device by Dr. Gibson and I understand the nature of the procedure to be: Gastric Stimulation Replacement

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

- I consent to the administration of such anesthetics as may be necessary or advisable by the anesthesiologist or anesthesiologist responsible for this service, with the exception of morphine - NO Zofen  
State "none" or specify unacceptable anesthetic
- I consent to the hospital authorities' disposal in accordance with accustomed practice of any tissues or parts which may be removed. My signature at the bottom of this page allows the hospital to release to me any explantable device removed from me at my request.
- For the purpose of advancing medical education, and / or for the purpose of performing the surgical procedure, I consent to the admittance of observers to the operating room, the photographing, filming and / or televising, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.
- I consent to the presence of manufacturer's representatives in the operating room for the purpose of supporting the physician with patient specific supplies and/or equipment.
- It is my intention to grant full authority to such physicians and surgeons and their respective employees and assistants, to administer and perform any and all drugs, treatments, tests or diagnostic procedures to or upon me which may be deemed advisable or necessary by the herein designated physician or surgeon, or any physicians or surgeons associated with him, or acting under their or any of their instructions.
- I ☒ DO DR ☐ DO NOT    consent to a transfusion of:

Blood or blood products that surgeons may deem necessary in the interest of my health and proper medical care. I understand the risks, benefits, and alternatives of a transfusion of blood or blood products. These risks exist despite the fact that the blood has been carefully tested.

I hereby certify that I have read and fully understand the foregoing authorization for medical and surgical treatment and the reasons why the above surgery is considered necessary, and that there are no blank spaces above my signature at the time of signing.

Julia Anna R. Terry P. Riley  
Witness Patient, Parent or Guardian Relationship

I have discussed and answered the patient's and/or legal guardian's questions related to the proposed anesthesia along with the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services and when indicated, any limitations on the confidentiality of information learned from or about the patient.

W. Gibson 7/31 10:55  
Physician's Signature Date Time

If patient unable to sign, state why.

This operative consent form shall remain valid and binding unless the patient is discharged from the physician's care prior to the time of the procedure or the patient / family in writing withdraws the consent.

## CONSENT AND AUTHORIZATION FOR MEDICAL / SURGICAL OPERATIONS TREATMENT OR PROCEDURE



028831600

OPM MR#00989930 DOB:03/23/1986

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2008 -

R10/07

00057 8008402

PRINTED BY: Mclemons

DATE 9/9/2009

BC 00546



**Saint Francis Hospital**  
Memphis



1000-555

### NOTICE REGARDING FACILITY DIRECTORY

Dear Patient/Patient's Personal Representative:

We maintain a list of information on our patients. This list is referred to in our *Notice of Privacy Practices (NPP)* as the Directory of Individuals. This Directory includes a patient's name, location in the hospital, general condition and religious affiliation. However, a patient's religious affiliation will only be disclosed to clergy.

We may use this information in the following ways:

**The Patient Information Desk** - uses the Directory to forward calls from friends or loved ones to a patient. They may use it to accept flowers or balloons sent to the patient. They use it to direct visitors to a patient's room.

**The Security Department** - uses the Directory to know at all times who is in the hospital, so they can prepare for any emergency and account for all patients.

**Telephone Operators** - use the Directory to forward calls to patients.

**Clergy** - use the Directory to make visits to patients and their families.

Every patient has a right to ask that their name, location in the hospital, general condition and/or religious affiliation be omitted from the Directory.

If you wish to be removed from this list, complete the *Directory Opt Out* form below.

### DIRECTORY OPT OUT FORM

Every patient has a right to ask that their name, location in the hospital, general condition or religious affiliation be omitted from the Directory. If you wish to remove all or part of your information from the Directory, please check those items that you do not want included:

- ☐ **Name** - If you select this box, we will not be able to share any information about you with anyone who asks for you by name, including family or friends. We will have to state that we cannot confirm or deny that you are a patient. *If you select this box, no additional selections are required.*
- ☐ **Location** - If you select this box, you cannot receive flowers, mail, phone messages, etc.
- ☐ **General Health Condition** - If you select this box, we cannot share information about your general condition with anyone who asks for you by name, including family or friends.
- ☐ **Religious Affiliation** - If you select this box, we cannot share information about you with clergy.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices (NPP), and is the patient, or the patient's personal representative.

7-31-09

Date

Time

*Terrill P. Riley*

Signature of Patient or Patient's Personal Representative

Relationship of Personal Representative to Patient (if applicable)

Print Name of Patient or Patient's Personal Representative

Directory Opt Out Form  
Page 1 of 1

R3/06



028631600

OPM MR#00989930 DOB 03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

00017 5506400

PRINTED BY: MClemons

DATE

9/9/2009

BC 00547



**Saint Francis Hospital**  
Memphis



1000-555

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Terril P. Riley  
Name of Patient

Terril P. Riley  
Signature of Patient

7/31/09  
Date Signed

\_\_\_\_\_  
Name of Patient's Personal Representative

\_\_\_\_\_  
Signature of Patient's Personal Representative

\_\_\_\_\_  
Date Signed

**FOR INTERNAL USE ONLY**

Emily Full  
Name of Employee

Emily Full  
Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.  
☐ Patient refused to sign.  
☐ Other \_\_\_\_\_

Version 2 (As noted on NPP)

12/08/03 (Date: As noted on NPP)

Notice of Privacy Practices  
(NPP) Acknowledgement  
Page 1 of 1



028831600

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRIL P F 43

GIBSON, WILLIAM 07/31/2009 -

R3/06

35.557 3378622

PRINTED BY: MClemons

DATE 9/9/2009

BC 00548

Gibson Terri Riley  
**Saint Francis Hospital**  
 Memphis 03-23-66



## Reason for Hospital Admission

Gastric Ascorbic Acid  
 Medical Doctor M. Fowler Last Visit 2-3-09

Date 07-27-09 Time 0920

Info Obtained From ☒ Patient and/or ☐ Sig. Other

Unable to take History ☐ Pt. unresponsive/unaccomp.

Agency currently providing assistance at home

☐ Home Health (Specify)

☐ Other

Emergency Contact

Relationship

Phone number

Advance Directive Form completed and on chart ☐

Last Flu shot 2008 Pneumonia shot none

Allergens (Drugs, Food, Tapes, Latex, Dyes, etc.)

Allergen Symptoms Treatment

Codine - Itching, Nausea  
Morphine  
20 mg - 200 mg IV

☐ NKA ☐ Allergy Bracelet On ☐ ID Bracelet On

Valuables Instructed Not To Keep ☐

☐ Sent Home - With Whom

☐ Given to Security-envelope#

**PATIENT HISTORY** (To be completed by patient / support person) Check each condition that applies.

- ☐ Glaucoma  
☐ High blood pressure (Hypertension)  
☐ Heart problems  
☐ Diabetes  
☐ Cancer

☒ Stomach / Bowel problems

☐ Hepatitis / Liver problems

☐ Thyroid problems

☐ Kidney problems

☐ Arthritis

☐ Seizures / Strokes

☐ Bleeding problems

☐ Ever received a blood transfusion

☐ Reaction to blood

☐ Take blood thinners

or Aspirin

☒ Anesthetic problems

patient or family

☐ Exposed to communicable disease

☐ Immunizations (pediatric)

☐ Are you pregnant?

☒ Date last menstrual period 07-07-09

☒ Breathing problems

☐ History of snoring

☐ Daytime sleepiness

☐ CPAP machine

☐ Use of Alcohol and/or Drugs ☐ Yes - How Much/How Long

☐ Use of Tobacco ☐ Yes - How Much/How Long

☐ No problems identified

HEIGHT 5'3" WEIGHT 113.17 BMI 19.6  
 B/P 100/60 P 80 R 16 Temp 98.8

**COMMENTS**

Gastric paresis

Signature of Nurse Reviewing History	Time	Date
<u>Julie Annas RN</u>	<u>0920</u>	<u>07-27-09</u>
<u>Julie Annas RN</u>	<u>7/31/09</u>	

**Patient Admission Assessment**

Page 1 of 2

R7108

028831600  
 OSD MAR0098930 DOB:03/23/1966  
 RILEY, TERRI P 43 F  
 GIBSON, WILLIAM 07/31/2009  
 SAINT FRANCIS HOSPITAL MEMPHIS

MR# DOB:

38357 3000132 PRINTED BY: MClemons

DATE 9/9/2009

BC 00549



# Saint Francis Hospital

## Memphis



1000-685

### PHYSICAL ASSESSMENT DATE

ORIENTATION: ☒ Oriented times 3  
☐ other

HEART: ☒ regular ☐ irregular ☐ murmur  
☐ other

RESPIRATIONS: ☒ regular/clear  
☐ other

COLOR: ☒ WNL ☐ other

SKIN TURGOR: ☐ WNL ☐ other

☐ See wound/skin assessment sheet

DISTAL PULSES: ☒ palpable ☐ Doppler  
☐ edema  
☐ other

ABDOMEN: ☒ soft/BG present  
☐ last bowel movement  
☐ other

### Neuro/Perceptual

Hearing: ☒ Normal ☐ Impaired ☐ R ☐ L  
☐ Uses Hearing Aids ☐ Aids with Patient  
☐ Lip Reads

Vision: ☒ Normal ☐ Impaired ☐ R ☐ L  
☐ Glasses ☐ Contacts ☐ Prosthesis ☐ R ☐ L  
☐ Aid with Patient & Instructed on Care  
☒ No Problems Identified

### Pain Assessment

Are you having Pain ☐ YES ☒ NO - If yes

Location: \_\_\_\_\_

Duration: ☐ Chronic ☐ Acute Rating (1-10) \_\_\_\_\_

Description: \_\_\_\_\_

Location: \_\_\_\_\_

Duration: ☐ Chronic ☐ Acute Rating (1-10) \_\_\_\_\_

Description: \_\_\_\_\_

Previous Surgeries / Hospitalizations Tireticon + Remon

Colonectomy Date: \_\_\_\_\_

Breast Augmentation Date: 02

Gastric Bypass Date: 05

Weight Loss Date: 06

Reduced gastric Date: 07

### NURSING DIAGNOSIS IDENTIFIED

Knowledge deficit R/T: Physician

Goal Met ☒ Yes ☐ No Initial SM

Anxiety R/T: \_\_\_\_\_

Goal Met ☐ Yes ☐ No Initial \_\_\_\_\_

Impaired verbal communication R/T: \_\_\_\_\_

Goal Met ☐ Yes ☐ No Initial \_\_\_\_\_

Other: \_\_\_\_\_

### Nutritional Care

If Abnormal, Notify Dietician to Evaluate

- ☐ On enteral or parenteral feedings ☐ High Risk OB  
☐ NPO or on clear liquids greater than 3 days ☐ Stage 3 or 4 Decubitus  
☐ Admitted with diagnosis of anorexia, liver failure, malnutrition, Failure to Thrive ☐ Unexpected or unintentional weight change (loss or gain)  
How many lbs \_\_\_\_\_ in what time frame? \_\_\_\_\_ (+/- 10 lbs in three weeks)  
☒ No Need Identified ☐ Dietician Consulted Initials: \_\_\_\_\_ Date/Time: \_\_\_\_\_

### Functional

Contact Physician for appropriate Referral

- ☐ CVA, fractures, new mobility impairment ☐ Unable to perform ADL's (onset within last month)  
☐ Newly identified weakness/paralysis ☐ Speech/swallowing difficulty  
☐ New onset of Falls ☐ Cardiac surgery, recent  
☐ Untreated lymphedema ☐ Acute MI, recent  
☒ No Need Identified ☐ Physician Notified Initials: \_\_\_\_\_ Date/Time: \_\_\_\_\_

### Social Services

Contact Social Worker for Referral

- ☐ Request by Patient ☐ Family situations or conflicts  
☐ Homeless/housing/transportation issues ☐ OD/suicide attempt  
☐ Financial issues ☐ Nursing Home resident/new Nursing Home placement  
☐ Evidence of abuse (physical - unexplained bruises or burns, sexual abuse, or neglect) ☐ Need for disability  
☒ No Need Identified ☐ Social Services Consulted Initials: \_\_\_\_\_ Date/Time: \_\_\_\_\_

### Discharge Planning

Contact Discharge Planning for Referral

- ☐ Needs care givers ☐ Assisted Living/Group Home resident  
☐ Needs home care/DME ☐ Hospice candidate  
☒ Rehab candidate  
☒ No Need Identified ☐ Case Management/Social Services Consulted Initials: \_\_\_\_\_ Date/Time: \_\_\_\_\_

### Patient Admission Assessment

Page 2 of 2

R7/08

MR# DOB:

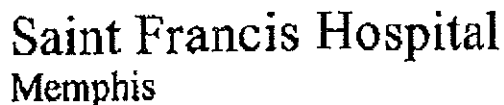
00017 3000400

PRINTED BY: MCLemmons

DATE

9/9/2009

BC 00550



**Date:**

Unit:

32

- |                              |    |
|------------------------------|----|
| <input type="checkbox"/> No  | 0  |
| <input type="checkbox"/> Yes | 25 |

- |   |    |
|---|----|
| <input type="checkbox"/> No             | 0  |
| <input checked="" type="checkbox"/> Yes | 15 |

- |                          |    |
|--------------------------|----|
| <input type="checkbox"/> | 0  |
| <input type="checkbox"/> | 15 |
| <input type="checkbox"/> | 30 |

- |                              |    |
|------------------------------|----|
| <input type="checkbox"/> No  | 0  |
| <input type="checkbox"/> Yes | 20 |

- 15

- |                          |    |
|--------------------------|----|
| <input type="checkbox"/> | 0  |
| <input type="checkbox"/> | 10 |
| <input type="checkbox"/> | 20 |

### Risk Score

Yes

No

Ye

No

1 yd

**No**

Nurse Initials

7-3 Intervention Initiated / Continued	3-11 Intervention Initiated / Continued	11-7 Intervention Initiated / Continued
<input checked="" type="checkbox"/> Additional lighting <input checked="" type="checkbox"/> Diversion activity <input checked="" type="checkbox"/> Bed low & locked <input checked="" type="checkbox"/> Top 2 rails up <input checked="" type="checkbox"/> Items within reach <input checked="" type="checkbox"/> Call light within reach <input checked="" type="checkbox"/> Pain needs assessment <input checked="" type="checkbox"/> Reorient to surroundings <input checked="" type="checkbox"/> Assist devices with reach <input checked="" type="checkbox"/> Decrease noise and stimuli <input checked="" type="checkbox"/> Instructed to call for assistance	<input type="checkbox"/> Additional lighting <input type="checkbox"/> Diversion activity <input type="checkbox"/> Bed low & locked <input type="checkbox"/> Top 2 rails up <input type="checkbox"/> Items within reach <input type="checkbox"/> Call light within reach <input type="checkbox"/> Pain needs assessment <input type="checkbox"/> Reorient to surroundings <input type="checkbox"/> Assist devices with reach <input type="checkbox"/> Decrease noise and stimuli <input type="checkbox"/> Instructed to call for assistance	<input type="checkbox"/> Additional lighting <input type="checkbox"/> Diversion activity <input type="checkbox"/> Bed low & locked <input type="checkbox"/> Top 2 rails up <input type="checkbox"/> Items within reach <input type="checkbox"/> Call light within reach <input type="checkbox"/> Pain needs assessment <input type="checkbox"/> Reorient to surroundings <input type="checkbox"/> Assist devices with reach <input type="checkbox"/> Decrease noise and stimuli <input type="checkbox"/> Instructed to call for assistance
Nurse Signature <i>[Signature]</i>	Nurse Signature	Nurse Signature

R6409

58257 3250625

PRINTED BY: MClemonn5

DATE \_\_\_\_\_

9/9/2009

BC 00551



# Saint Francis Hospital Memphis

## HOW TO USE THE MORSE FALL SCALE RISK SCREENING TOOL:

**1. History of Falling:** Yes (scored 25), if a previous fall is recorded during the present admission or if there is immediate history of physiological falls (i.e., from seizures, impaired gait) prior to admission.

**2a. Secondary Diagnoses:** Yes, if more than one medical diagnosis is listed on the patient chart. It is here that medications can be surmised that may contribute to falls, e.g., seizure disorders - anti-seizure medications; HTN & CHF - diuretics, anxiety-berzodiazepines; psychoses-dementia- psychotropic drugs; Insomnia - sedative-hypnotics; acute or chronic pain- narcotic analgesics (HOWEVER, ANY SECONDARY DIAGNOSES SHOULD BE CONSIDERED).

**2b. If there are 'NO' Secondary diagnoses present,** the nurse assessing the patient's presenting signs & symptoms should consult a pharmacist to rule out any risk for falls. This may include patients undergoing bowel preps for colonic radiology studies or colonoscopies.

### **3. Ambulatory Aids:**

Scored '0' if patient walks without a walking aid even if assisted by a nurse or is not on bed rest.  
Scored '15' if ambulatory with crutches, cane or walker.  
Scored '30' if furniture for support

**4. Intravenous Therapy:** Scored '20' if has an IV apparatus or heparin lock.

### **5. Mental Status:**

Scored '0' - The patient is asked if s/he is able to go to the bathroom alone or if s/he is permitted up. If the patient's response is consistent with the ambulatory orders on the practitioner's orders.  
Scored '15' - The response is not consistent with the order or if the patient's assessment is unrealistic

### **6. Gait:**

Scored '0' - Normal Gait- if patient is able to walk with head erect, arms swinging freely at the side, and strides unhesitantly.  
Scored '10' - Weak Gait- if patient stooped but able to lift head while walking. Furniture support may be sought, but is feather-weight touch, almost for reassurance. Steps are short, and the patient may shuffle.  
Scored '20' - Impaired Gait- if patient stooped, may have difficulty rising from the chair, attempts to rise by pushing on chair arms and/or "bouncing." The patient's head is down and because balance is poor, the patient grasps the furniture, a person, or walking aid for support and cannot walk without assistance. Steps are short and patient shuffles. If patient is wheelchair-bound, the patient is scored according to the gait used when transferring from the wheelchair to the bed.

Morse Fall Scale Risk

Page 2 of 2

R6/09



MR# DOB:

20090909

PRINTED BY: MClemons

DATE: 9/9/2009

BC 00552

# Francis Hospital

## Memphis



### PROCEDURE OBSERVATION NOTES

Procedure: Gastric Pacer Am. &  
☒ OR ☐ GI Lab ☐ Radiology ☐ Other  
☒ General ☐ Local with sedation ☐ Local ☐ Block  
 Date: 7/21/09 Time Returned: 1320  
 VS: B/P 90/62 AP 77 R 16 T 97.2  
☐ A/O ☒ Drowsy ☐ Other  
 Resp. ☒ Reg./Clear ☐ Irreg. ☐ Other  
 Skin: ☒ Warm ☐ Pink ☐ Pale ☐ Other  
 Surg. Site: Rt. lower Abt. site  
1. Decontaminate

Pain: ☐ Yes ☐ No, Intensity (0-10) 1 Location: \_\_\_\_\_  
 Patient Education Regarding \_\_\_\_\_  
 Pain/Pain Management: ☒ Yes ☐ No  
 NV: ☐ Yes ☒ No P.O. Fluids given: ☒ Yes ☐ No  
 Mobility: ☒ Intact times 4 Ext. Other \_\_\_\_\_  
 Distal Pulses: ☒ Palpable Other \_\_\_\_\_  
 IV: LRT LTV 802 Site: Rt. A  
 Condition: ☒ No R/S or pain Other \_\_\_\_\_  
 Fall Precautions: ☒ Call Light within reach  
☒ Bed Low/Locked  
☒ Voices understanding

Comments: instructed to be quiet  
Rt. to home - follow to face  
(2 redness noted)

TIME	BP	P	R	PAIN 0-10	OBSERVATIONS	Init.
1320	90	62	16	1	No itching - much	
					Slightly red -	
					Drains discontinue	
1415	95	78	16	1	Drains discontinue	
					Discomfort. Incom	
					S. to dry & Steri	

Time	Medication	Route	Site	Init

### DISCHARGE SUMMARY

#### NURSING DIAGNOSIS IDENTIFIED

☒ Knowledge Deficit RT post-op care  
 Goal Met ☐ Yes ☐ No ☐ Initial  
☐ Potential for Injury RT \_\_\_\_\_  
 Goal Met ☐ Yes ☐ No ☐ Initial  
☐ Alterations in Comfort RT \_\_\_\_\_  
 Goal Met ☐ Yes ☐ No ☐ Initial  
☐ Potential Alteration in Body Temp RT \_\_\_\_\_  
 Goal Met ☐ Yes ☐ No ☐ Initial  
 Explain Any Unmet Goals: \_\_\_\_\_

### DISCHARGE MEDICATIONS

<u>Danacet - N 100</u>	

IV solution added \_\_\_\_\_ Time \_\_\_\_\_  
 IV: Discontinued at 1410 LTC 600  
 Condition: ☒ No R/S or pain Other \_\_\_\_\_

Nurse's Initials JS  
 Surg. Site: ☐ Clean/dry/intact Other \_\_\_\_\_

Tpt. oral fluids: ☒ Yes ☐ No Ambulated: ☒ Yes ☐ No  
 Voided: ☒ Yes ☐ No ☐ N/A

Drug Interaction Sheet Given: ☐ Yes ☐ No

Teaching/Instructions given with copy ☐ Yes ☐ No

Verbalized Understanding ☒ Yes ☐ No

Discharged VS: B/P 95/72 AP 78 R 16 T 98.1

Discharged To: Home Via W/C

Discharging Nurse Initials JS Time 1430

Referrals Requested		
Department	Purpose	Called By
Initials	Signature	TRG
<u>JS</u>	<u>Thomas Shand</u>	
<u>JS</u>	<u>Wally Gorman</u>	

### POST PROCEDURE OBSERVATION NOTES

Page 1 of 2

R602



028831500

OPM MR#00989930 DOB:03/23/1966

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009 -

0025 3008432

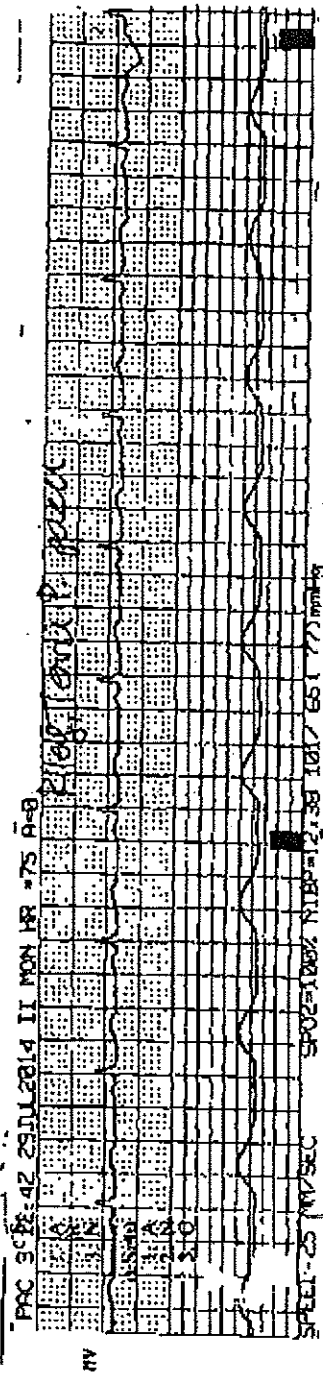
PRINTED BY: MClemmons

DATE 9/9/2009

BC 00553

[illegible]

BC 00554



RILEY, TERRI P  
 DOB: 03/23/1966 43 F ACCT# 028831600  
 GIBSON, WILLIAM  
 MR#: 00989930 07/31/2001

08757 5003437

PRINTED BY: MClenmons

DATE 9/9/2009

BC 00555



# Saint Francis Hospital Memphis



601-771

## Section I: INITIAL ASSESSMENT

Physical Barriers to Learning: ☒ None ☐ Vision ☐ Hearing  
☐ Language (explain) \_\_\_\_\_ ☐ Reading (explain) \_\_\_\_\_  
☐ Writing (explain) \_\_\_\_\_  
☐ Development level requiring intervention (explain) \_\_\_\_\_  
☐ Other \_\_\_\_\_  
 Emotional Barriers to Learning:  
☒ None ☐ Anxiety ☐ Anger ☐ Denial ☐ Depression ☐ Confusion ☐ Other \_\_\_\_\_  
 Spiritual Barriers to Learning: ☒ None ☐ Grief ☐ Lack of Hope ☐ Guilt ☐ Other \_\_\_\_\_  
 Home Barriers to Compliance:  
☒ None ☐ Meal Prep ☐ Transportation ☐ Financial ☐ Caregiver ☐ Other \_\_\_\_\_  
 Religious and/or Cultural Barriers to Learning:  
☒ None ☐ Yes, explain \_\_\_\_\_

- What is the easiest way for you to learn? ☐ Reading ☐ Listening ☐ Pictures ☐ Demonstration  
☐ Other \_\_\_\_\_
- What are your learning needs at this time? Prioritize 1 = high, 2 = moderate, 3 = low ☐ None  

Priority	Priority	Priority
<input type="checkbox"/> Disease Process	<input type="checkbox"/> Medication	<input checked="" type="checkbox"/> Follow Up Treatment
<input type="checkbox"/> Use of Equipment	<input type="checkbox"/> Diet	<input checked="" type="checkbox"/> Pre/Post Op Teaching
<input type="checkbox"/> Community Resources	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other
- Is there someone we should involve in your teaching? ☐ No ☒ Yes: \_\_\_\_\_
- Rate your desire/motivation to learn. ☒ High ☐ Moderate ☐ Low

Initial Assessment Completed by Julie Ann Rimmer RN Date 7-31-09 Time 10:15

## Section II: POTENTIAL TEACHING TOPICS

- |                      |                            |                          |                          |                        |                     |
|----------------------|----------------------------|--------------------------|--------------------------|------------------------|---------------------|
| 1. Activity/Exercise | 8. Disease Process         | 15. Incentive Spirometry | 22. Mouth Care           | 29. Pre-Op Teaching    | 36. Social Services |
| 2. Admission         | 9. Discharge Equipment     | 16. Infant Care/feeding  | 23. New Meds             | 30. Psychosocial Needs | 37. Spiritual Needs |
| 3. Advance Directive | 10. Dressings              | 17. Isolation Precaution | 24. Outpatient Programs  | 31. Restraints         | 38. Surgery         |
| 4. Comm. Resources   | 11. Follow-up Care         | 18. IV/injections        | 25. Pain Management      | 32. Risk Factors       | 39. TCOB            |
| 5. Diagnostic Tests  | 12. Foley                  | 19. Labor Management     | 26. Plan of Care         | 33. Room Orientation   | 40. Tests           |
| 6. Diet/NPO          | 13. Food/Drug Interactions | 20. MDI/Nebulizers       | 27. Post-Op Teaching     | 34. Safety/Fall        | 41. Treatments      |
| 7. Disease Mgmt.     | 14. Home Care Services     | 21. Monitors             | 28. Post Partum Teaching | 35. Signs/SX           | 42. Wound Care      |

## Section III: PATIENT/FAMILY EDUCATION RECORD

DATE	TIME	DEPARTMENT	EDUCATION PROVIDED	RESPONSE 1,2,3	EDUCATION PROVIDED TO:	INITIAL
7/31/09	0920	ORS	3, 6, 29 11-23 25 26 27	1	PT Rimmer	MR JR

- Demonstrates understanding by verbal or return demonstration.
- Demonstrates partial understanding - needs reinforcement of education.
- Unable to provide education to patient / significant other. Alternative plan to education provided.

Signature / Title	Initial	Signature / Title	Initial
<u>Julie Ann Rimmer RN</u>	<u>MR</u>		
<u>Julie Ann Rimmer RN</u>	<u>JAR</u>		

PATIENT FAMILY EDUCATION  
MULTIDISCIPLINARY  
Page 1 of 2

R5/02

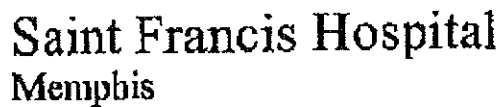
02983:500  
OSD MR#00989930 DOB:03/23/1965  
RILEY, TERRI P 43 F  
GIBSON, WILLIAM 07/31/2009  
SAINT FRANCIS HOSPITAL MEMPHIS

MR# DOB:

PRINTED BY: Mclemmons

DATE 9/9/2009

BC 00556



'601-771

[illegible]

### Key to Response

1. Demonstrates understanding by verbal or return demonstration.
2. Demonstrates partial understanding - needs reinforcement of education.
3. Unable to provide education to patient / significant other. Alternative plan to education provided.

[illegible]

Comments: \_\_\_\_\_

[illegible]

**PATIENT FAMILY EDUCATION  
MULTIDISCIPLINARY**  
Page 2 of 2



RA/02

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DATE 9/9/2009

BC 00557



**Saint Francis Hospital**  
Memphis



1030-380

### PATIENT EDUCATION REGARDING SMOKING

#### Quick Facts about Smoking

Smoking-related diseases claim an estimated 430,700 American lives each year. Smoking costs the United States approximately \$97.2 billion each year in health-care costs and lost productivity. It is directly responsible for 87 percent of lung cancer cases and causes most cases of emphysema and chronic bronchitis. One in three smokers die early because of their smoking. They die of heart disease, stroke, cancer and emphysema. What's more, research shows that secondhand smoke, the smoke from other people's cigarettes, can harm the health of nonsmokers. Breathing in another person's smoke can cause many breathing problems in children and cancer and heart disease in adults.

#### Saint Francis Hospital Policy/Rules about Smoking

1. Saint Francis is a nonsmoking institution. Strict guidelines regarding smoking by patients and visitors must be followed. Patients may **NOT** smoke in patient rooms. There are no designated smoking areas anywhere on Saint Francis property, including parking garages.
2. We encourage the use of alternatives instead of smoking. Your physician has the ability to order nicotine replacements for you to assist in quitting smoking while you are hospitalized. We also will provide you with information on the best methods to quit smoking. Your nurse will provide that information to you on request. Failure to comply with our No smoking policy could result in your being discharged against medical advice.
3. If you do not follow the rules regarding smoking, you are subject to have your smoking materials removed from your room, in order to safeguard you, as well as others. The rules have been established for safety reasons as well as health concerns.
4. Smoking in heart patients can result in heart irregularities and sudden death.

I have read the above and have had the opportunity to have any questions I may have asked answered. I understand the rules, and I agree to abide by them while a patient at Saint Francis Hospital. If I do not follow the above policy, I understand that I am responsible for any damage to property, myself, or others and I agree to hold harmless Saint Francis Hospital, its affiliates and their agents and employees from any claims or causes or action which may arise out of my failure to follow the policy.

*Terrill P. Riley*  
Patient Signature

#### Patient Education Regarding Smoking

Page 1 of 1

R05/07



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OSD MR#00989930 DOB:03/23/1968

RILEY, TERRILL P F 43

GIBSON, WILLIAM 07/31/2009

00237 3000-187

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DATE 9/9/2009

BC 00558



# Saint Francis Hospital

## Memphis



1000-557

### TO THE PATIENT:

If you are having a procedure done by one of the following departments, you can expect to receive two (2) separate bills. One will be from Saint Francis Hospital Memphis to cover the procedure itself and the other from the physician who interprets the results of your test. They will bill you separately. This fulfills the legal requirements established by the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248).

Cardiology:	ALL TESTS East Memphis Electrocardiographers PO Box 241928 Memphis, TN 38124-1926 - Telephone: (901) 384-6554		
Radiology Nuclear Medicine Radiation Therapy:	ALL TESTS Memphis Physicians Radiology Group, PC 2527 Cranberry Hwy. Wareham, MA 02571 - Telephone: (800) 299-9770		
G.I. Lab:	ERCP TESTS Memphis Physicians Radiology Group, PC Department 198, PO Box 1000 Memphis, TN 38148 - Telephone: (901) 761-2160		
Neurophysiology:	ADE EMG and SINGLE FIBER EMG TEST <table border="1"> <tr> <td>Dr. Alan M. Nadel PO Box 41819 Memphis, TN 38174 Telephone: (901) 728-8916</td><td>Dr. Mohammad Asraf 8005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880</td></tr> </table>	Dr. Alan M. Nadel PO Box 41819 Memphis, TN 38174 Telephone: (901) 728-8916	Dr. Mohammad Asraf 8005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880
Dr. Alan M. Nadel PO Box 41819 Memphis, TN 38174 Telephone: (901) 728-8916	Dr. Mohammad Asraf 8005 Park Ave., Suite 722B Memphis, TN 38119 Telephone: (901) 761-1880		
Pathology:	Tissue pathology, cytology, clinical lab consultations, biopsy procedures, and fees for supervisory services when a sample of your blood, urine, stool or other body fluid is tested in the laboratory to insure clinical reliability, timely reporting, consultation with treating physicians or interpretation of results.  The Pathology Group, PC 6080 Primacy Parkway, Suite 439 Memphis, TN 38119 - Telephone: (901) 681-9087		
Surgery:	The package price includes the following: surgical suite and supplies, recovery room, outpatient preparation and postoperative observation, CBC and urinalysis, anesthesia supplies, routine medications and routine pathology studies.  This special price does not include the following: charges for prosthetic devices, surgeon's fees, anesthesiologist or anesthesiologist fees which may be billed by the hospital, other physician-related fees or take-home drugs. Moreover, Saint Francis Hospital Memphis reserves the right to exclude those rare extraordinary charges from its special ambulatory pricing schedule and will bill the patient accordingly.		
Self Pay:	The price you have been quoted is an estimated amount. There may be additional charges incurred during your testing for which you will receive a statement.		

For information concerning hospital charges, call (901) 765-1850. For questions about Medicare and Medicaid, call (901) 765-1877.

731-09  
Date

*Terril P. Riley*  
Patient/Patient's Authorized Signature

*Emily Kelly*  
Witness

If other than patient, indicate relationship

Witness

Witness

Separate Physician Billing  
Page 1 of 1



028831600

OSD MR#00989930 DOB: 03/23/1965

RILEY, TERRI P F 43

GIBSON, WILLIAM 07/31/2009

R3J06

081257 5633037

PRINTED BY: MClemons

DATE

9/9/2009

BC 00559



BlueCross BlueShield  
of Mississippi

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SOS 140114000 Rev 3/03

PLEASE RETAIN THIS INFORMATION  
FOR PERSONAL USE.

# EXPLANATION OF BENEFITS

P.O. Box 1043  
Jackson, Mississippi 39215-1043  
Phone: (601) 932-3704  
Toll-Free Phone: 1-800-222-8046

SUBSCRIBER INFORMATION	
Insured	JAMES P RILEY
Identification No.	868284547M
Date	08/31/09

Page 2 of 3

-CONTINUED FROM PREVIOUS PAGE-

Patient: TERRI P RILEY				Relationship: SUBSCRIBER SPOUSE							Claim # 92280203	
Provider: SAINT FRANCIS HOSPITAL				Patient Account # 028831600								
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider		
	From	To		Amount	Code							
HE	07/31/09	07/31/09	42,524.27	42,524.27	MD	0.00	0.00	0.00	0.00	42,524.27		
	Totals:		42,524.27	42,524.27		0.00	0.00	0.00	0.00	42,524.27		

HE-HOSPITAL EXPENSE

WE MEDICAL NECESSITY DOCUMENTATION NOT RECEIVED.

Patient: TERRI P RILEY						Relationship: SUBSCRIBER SPOUSE					Claim # 922841541	
Provider: Real, Ellis G.						Patient Account # C0918810497						
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider		
	From	To		Amount	Code							
M	07/08/09	07/08/09	42.00	29.56	49	0.00	1.24	0.00	11.20	1.24		
	Totals:		42.00	29.56		0.00	1.24	0.00	11.20	1.24		

M-MISCELLANEOUS MEDICAL

49-THIS PROVIDER HAS AGREED NOT TO BILL YOU FOR THIS INELIGIBLE AMOUNT.

Patient: TERRI P RILEY					Relationship: SUBSCRIBER SPOUSE			Claim # 923242141		
Provider: Hall, Johnnie C.					Patient Account # K4WKBP 252200040892					
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider
	From	To		Amount	Code					
I	07/07/09	07/07/09	28.54	28.54	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	25.22	25.22	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	9.86	9.86	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	14.00	14.00	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	23.26	23.26	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	29.82	29.82	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	14.98	14.98	49 16	0.00	0.00	0.00	0.00	0.00
I	07/07/09	07/07/09	13.14	13.14	49 16	0.00	0.00	0.00	0.00	0.00
I	07/08/09	07/08/09	4.12	4.12	49 16	0.00	0.00	0.00	0.00	0.00
Totals:			100.94	100.94		0.00	0.00	0.00	0.00	0.00

I-DIAGNOSTIC PROFESSIONAL COMPONENT INTERPRETATION

16-EXCEEDS ALLOWANCE-NOT OWED BY PATIENT

-CONTINUED ON NEXT PAGE-

BC 00476

0092856.00530



BlueCross BlueShield  
of Mississippi

BlueCross BlueShield of Mississippi is a mutual insurance company  
and a subsidiary of the Blue Cross and Blue Shield Association  
BCBS 2407150208 Rev 3/03

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### EXPLANATION OF BENEFITS

P.O. Box 1043  
Jackson, Mississippi 39215-1043  
Phone: (601) 932-3704  
Toll-Free Phone: 1-800-222-8046

SUBSCRIBER INFORMATION	
Insured	JAMES P RILEY
Identification No.	868264547M
Date	09/30/09

Page 3 of 4

-CONTINUED FROM PREVIOUS PAGE-

Patient: TERRI P RILEY				Relationship: SUBSCRIBER SPOUSE				Claim # 943241290		
Provider: Patil, Mahadev R.				Patient Account # RILEY0008						
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider
	From	To		Amount	Code					
N	07/31/09	07/31/09	840.00	840.00	A5	0.00	0.00	0.00	0.00	840.00
	Totals:		840.00	840.00		0.00	0.00	0.00	0.00	840.00

N-ANESTHESIOLOGY

A5-SERVICES NOT MEDICALLY NECESSARY

CLAIM REPROCESSED

Patient: TERRI P RILEY			Relationship: SUBSCRIBER SPOUSE								Claim # 942280203	
Provider: SAINT FRANCIS HOSPITAL			Patient Account # 028831600									
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider		
	From	To		Amount	Code							
HE	07/31/09	07/31/09	42,524.27	42,524.27	A5	0.00	0.00	0.00	0.00	42,524.27		
	Totals:		42,524.27	42,524.27		0.00	0.00	0.00	0.00	42,524.27		

HE-HOSPITAL EXPENSE

A5-SERVICES NOT MEDICALLY NECESSARY

CLAIM REPROCESSED

Patient: TERRI P RILEY				Relationship: SUBSCRIBER SPOUSE				Claim # 925341194		
Provider: Berry III, Allen D.				Patient Account # TPG02883160001						
Type of Service	Service Date		Charge	Ineligible		Deductible Applied	Co-Insurance / Co-Pay	Paid by Other Ins.	Total Benefit Paid	What You Owe To The Provider
	From	To		Amount	Code					
I	07/31/09	07/31/09	49.00	43.52	49	0.00	0.55	0.00	4.93	0.55
	Totals:		49.00	43.52		0.00	0.55	0.00	4.93	0.55

I-DIAGNOSTIC PROFESSIONAL COMPONENT INTERPRETATION

49-THIS PROVIDER HAS AGREED NOT TO BILL YOU FOR THIS INELIGIBLE AMOUNT.

BC 00473